Submitter : Dr. Joanne Festa **Date & Time:** 09/17/2004 06:09:21

Organization : Columbia University Medical Center

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

Thank you for the opportunity to comment on this very important matter.

Sincerely,
Joanne R. Festa, PhD
Assistant Professor Of Clinical Neuropsychology
Columbia University, College of Physicians & Surgeons
New York Presbyterian Hospital

Submitter : Rebecca Crosby **Date & Time:** 09/17/2004 07:09:45

Organization : Pill Box Pharmacy

Category : Device Industry

Issue Areas/Comments

Issues 20-29

ASSIGNMENT

Mastectomy supplies should be exempt from the prescription requirements. I believe this will make an undue influx of patients needing appointments with already very busy physicians. You are asking physicians and patients to inconvenience themselves for an appointment which is not physically or medically needed for health. Plus, this will be costly to Medicare for these office visits. Patients who have had a mastectomy or lumpectomy will need these supplies for the REST OF THEIR LIVES! Why do they really even need a prescription each year? Who is abusing this?
Many patients have had physicians appointments, oncology appointments, and radiation appointments for months on end. They are tired! Requiring the patient to see the post mastectomy fitter within 30 days is an extreme imposition. Please remember, you may be this person someday.
Later on, after treatments are over most patients see their physicians at least 1-2 times per year. If they have been seen, there should not be a problem with acquiring a prescription which should be good for one year. Why can a controlled substance such as Vicodin be good for 6 months from day of issue and a bra prescription only good for 30 days. That makes no logical sense!!
Thank you for listening to our point of view. Please let us know you received this and did read it. beckycrosby@pillboxpharmacy.com

Submitter : Ms. Mariah Parker **Date & Time:** 09/17/2004 07:09:03

Organization : NATA

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 15, 2004
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012
Re: Therapy ? Incident To
Dear Sir/Madam:
I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.
During the decision-making process, please consider the following:
? ?Incident to? has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
? There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY ?incident to? service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
It is in the best interests of patients and physicians as well as being a cost effective benefit to CMS.

Please rethink your changes,
Mariah Parker A.T.,C.

CMS-1429-P-1903

Submitter : John Fowler **Date & Time:** 09/17/2004 07:09:12

Organization : University of Wisconsin Hospital

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-1903-Attach-1.doc

Attachment #1903

John Fowler
UW Health – UWHC
621 Science Drive
Madison WI 53711

September 17, 2004

Centers For Medicare And Medicaid Services
Department of Health & Human Services
Attn: CMS-1429-P
PO Box 8012
Baltimore MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing this letter to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. It would, in turn, reduce the quality of health care for our Medicare patients, ultimately increase the costs associated with this service, and place an unnecessary burden on the health care system.

The purpose of this letter is to offer some background information regarding how our clinic at the University of Wisconsin functions and to illustrate how these proposed rule changes would compromise our ability to continue to deliver high quality health care to our patients.

The University of Wisconsin Hospital & Clinics Sports Medicine Center, staffed by eight physicians, provides high quality health care to more than 15,000 patients per year. Critical to our model of care is the direct involvement of state of Wisconsin licensed athletic trainers, physical therapists, and physician assistants in evaluating, educating, and treating outpatients in our clinic. On a daily basis, these providers work under the direct supervision of attending physicians and perform initial evaluations, coordinate the ordering of diagnostic tests such as x-rays and MRIs, educate patients regarding disease process, and offer injury rehabilitation guidelines. Such cost-effective comprehensive care would be impossible without this full complement of allied health providers. In our particular clinic the licensed athletic trainers and physician assistants constitute approximately 90% of our allied health care personnel. If they were prevented from offering "incident to" services, many of these important tasks would fall upon the physicians. Not only would this mean that significantly fewer patients could be seen in a timely manner but, more importantly, the high quality of care offered would be

diminished since, as a group, allied health providers generally spend more time and do a superior job on patient education than the physicians.

Lastly, all practicing athletic trainers in the State of Wisconsin are licensed health care providers. Their scope of practice is clearly defined and the necessity of physician supervision is also definitively stated on their license. Therefore, at least in our state, there is no possibility of licensed athletic trainers practicing outside of a reasonable scope of practice without adequate supervision.

In closing, I hope that you will reconsider who can deliver "incident to" services in physician clinics. Based upon the critical involvement of state licensed athletic trainers and physician assistants in providing high quality health care services to our entire spectrum of patients, I would strongly encourage you to consider adding these professional clinicians to your list of approved health care providers.

Sincerely,

John B. Fowler, MS LAT
Licensed Athletic Trainer
UW Hospital & Clinics Sports Medicine Center

Submitter : Mrs. JACKIE FIELDS **Date & Time:** 09/17/2004 08:09:49

Organization : VDK TURNING POINT

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I'm not a cancer survivor and hope I'm never faced with being one, but I work with ladies every day who are and ones that do not survive. This would be unfair, costly and not practical for these ladies. Some of these ladies live in rural areas and don't get out very often. They don't like having to go back to the doctor for unnecessary vists that cost them time and money. It will cost medicare more money because you will have to pay an office vist. The doctors won't like it either. It will give them a larger work load. They are already overworked. The chest isn't going to change. This is a permanent thing, so why should they have to get a perscription every year? She will need mastectomy products for life. Thank You Jackie Fields.

Submitter : Sue StanleyGreen , MS **Date & Time:** 09/17/2004 08:09:06

Organization : Florida Southern College

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-1905-Attach-2.doc

CMS-1429-P-1905-Attach-1.doc

Attachment #1905 (1 of 2)

Sue Stanley-Green, MS, ATC/L
Athletic Training Program Director
Florida Southern College
111 Lake Hollingsworth Dr.
Lakeland, FL 33801

September 17, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those

groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Sue Stanley-Green, MS, ATC/L
Athletic Training Program Director
Florida Southern College

Attachment #1905 (2 of 2)

Sue Stanley-Green, MS, ATC/L
Athletic Training Program Director
Florida Southern College
111 Lake Hollingsworth Dr.
Lakeland, FL 33801

September 17, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

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- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those

groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Sue Stanley-Green, MS, ATC/L
Athletic Training Program Director
Florida Southern College

CMS-1429-P-1906

Submitter : Mr. Andrew Bryda **Date & Time:** 09/17/2004 08:09:04

Organization : Greensboro College

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Kinesiology Department
Greensboro College
815 West Market St.
Greensboro, NC 27401

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

As a future Certified Athletic Trainer (ATC) and possible future patient, I feel compelled to write this letter in opposition of proposal CMS-1429-P. I am concerned that this proposal would limit patient access to qualified health care providers of ?incident to? services, such as ATCs, in physician offices and clinics; thereby, reducing the quality of health care for physically active patients. Furthermore, limiting access to qualified health care providers will cause delays in the delivery of health care, which in turn will increase health care costs and tax an already heavily burdened health care system.

Athletic training is the health care profession that specializes in the prevention, assessment, treatment and rehabilitation of injuries to athletes and others who are engaged in everyday physical activities. Athletic trainers are multi-skilled health care professions who can, and are, making significant contributions to health care. Athletic trainers are highly educated and fully qualified health care profession. If this proposal would pass, it would threaten the employment of many athletic trainers who are employed as physician extenders in clinics and physician offices. Therefore this proposal threatens my future employment in those settings and the value of my degree in Athletic Training. With this type of limitation artificially placed on the provision of ?incident to? services by qualified (through accredited academic programs in athletic training, a national board examination and state practice acts) health care providers the CMS will only add to the skyrocketing health care costs, put qualified people out of work and reduce the overall quality of health care in the United States.

In conclusion, I believe that the CMS-1429-P proposal must be rejected in order to protect the rights (the right to choose and the right for quality care) of our patients and my right as a future health care practitioner.

Sincerely,
Andrew Bryda
Athletic Training Student at Greensboro College, Greensboro, NC

CMS-1429-P-1907

Submitter : Mrs. Susan Hillger **Date & Time:** 09/17/2004 08:09:49

Organization : Providence Hospital

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am writing to express my concern over the recent proposal that would limit providers of 'incident physician clinics. If adopted, this would eliminate the ability of qualified health care professional to these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.
Pplease consider the following:
1. Incident to has,since the inception of the Medicare program in 1965, been utlized by physicians to allow others, under the direct supervision of the physician to provided services as a adjunct to the physician's professional services. A physician's choice of qualified therapy providers inherent in the type of practice, medical subspeciality and individual patient.

2. There havenever been any limitations or restrictions placed upon the physician in terms of who he or she can utlize to provide ANY incident to service. Because the physician accepts the legal responsibility to the individual under his or her supervision, Medicare and private payers have always relied upone the professional judgement of the physician to be able to determine who is or is not qualified to deliver that particular service. It is imperative that physicains continue to make decisions in the best interest of their patients.

3. In many cases, the change to 'incident to' services reimburement would render the physician unable to provide hir or her patients wtih comprehensive, quickly accessible health care. The patients would be forced to see the physician and sepatately seek therapy treatment elsewhere, causing a significant inconvience and additional expense to the patient.

4. This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in the rural and outlying areas. If the phsycians are not longer allowed to utlize a variety of qualified health care professionals working 'incident to' with the physician, it is likely to suffer delays in health care, greater cost and lack of local and immediate treatment.

5. Patients who would now be referred outside of the physician's office would incur delays espically inthe case of rural Medicare patients, this couldnot only involve delays but, as mentions above impact patients in time and travel expense. Delays would hinder the patients recovery and/or increase rehabilitation time, which would ultimately add to the medical expenditures of Medicare.

6. Curtailing to whom the physician can delegate 'incident to' procedures will result in physician's performing more of these routine treatment themselves. Increasing the workload of physicians whom are already too busy. This will take away from the phsyician's ability to provide the best possible care. I already see this with therapy. Since regulating that only therapist's can deliver treatment to the Medicare patients, the wait time to gain access to therapy clinics has increased and the amount of time that therapists have to provide quality of care has decreased. The regulation has done nothing but frustrate the professionals, as well as the patients.

7. CMS does not have the statuatory authority to restrict who can and cannot provide services in a physician office visit. IN fact, this action could be construed as an unprecedented attempted on behest of a specifice type of health professions, to seek exclusivity as a provider of physician services.

8. Athletic trainers are employed by almost every U.S. post-secondary educational institutional athletic program and every professional sports team in America to work with athletes to pre-treat/rehabilitate injuries sustained during athletic competition. Also, dozens of athletic trainers traveled with the U.S. Olympic Team to Athens, Greece this summer to provide services to our top athletes. They are qualified to care for Medicare patients.

Susan Hillger MPT

CMS-1429-P-1908

Submitter : Ms. Deborah Johnson **Date & Time:** 09/17/2004 09:09:13

Organization : Sutter Santa Cruz Medical Foundation

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

September 2004

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS Code 1429-P

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

Please reconsider your proposed rule. CMS committed in 1996 to updated the physician payment localities if there has been a significant change in practice costs. Santa Cruz County remains the most disadvantaged county in California. The payment differential for physician services in a county less than 20 miles from where I live is over 25% greater than for services that I receive from my doctor. I understand that this is by far the greater such differential in the country.

This needs to stop. We are losing doctors and important specialties. I cannot fathom how this is allowed to continue. I believe that Congress has delegated to CMS the responsibility to manage the payment to physicians. I believe that no other county in the U.S. is in greater need of reform than our county. It is your responsibility to correct this problem. Continued postponement of this long-needed reform is ill-advised and inappropriate.

Sincerely,

Deborah Johnson CCMA-C, CPC

CMS-1429-P-1909

Submitter : Jane Smith **Date & Time:** 09/17/2004 09:09:58

Organization : Jane Smith

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a physical therapist and an athletic trainer. I know both curriculums of education and training intimately. Physical therapists are the only rehab professionals that are qualified to work with Medicare patients. Athletic trainers (ATC's)are not trained or educated to work with the elderly, the neurological patient, children, hospitalized patients or anyone but active athletes. ATC's are thoroughly educated to work with a specific athletic population, probably more so that physical therapists, but ATC's are not knowledgable, safe, or trained enough to be able to serve the needs of seniors. Most ATC's will willingly acknowledge this; indeed, that is why they chose to go into athletic training instead of physical therapy -- because they wanted to work with active athletes. ATC's who are demanding to be able to work with Medicare patients are simply making a power grab -- they want the world to think they can treat anyone who has a physical impairment. This is simply not true. Please do not allow this minority to try to practice out of their scope of training, historical practice or experience.
Please make these comments available to:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS-1429-P-1910

Submitter : Ms. Mary Rosenberg **Date & Time:** 09/17/2004 09:09:50

Organization : Hollywood Physical Therapy Associates

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I have been a physical therapist since 1978 in the state of California. I have owned a private physical therapy practice in Hollywood since 1991.I have seen many patients who over the years have received services for physical therapy that were billed to Medicare but were administered by a non licensed person working in an MD's office. All of those patients expressed their discontent with the services that they said either made them worse or were not helpful. In some cases, patients were actually injured because the aides treating them in MD offices did not understand precautions and contraindications. (Aides are not able to document and work towards functional goals nor can they do PT evaluations.) Those services were billed to Medicare and sometimes at a higher rate than what we private practice physical therapists bill. CMS should not provide payment for non professional services billed as PT when those services are only supervised by physicians who do not practice physical therapy themselves especially when PT's are not allowed to supervise aides why should someone who is not a licensed PT and who has not gone to PT school (7 years for a DPT degree)be reimbursed for professional services that are not administered by a professional. MD's are skilled in their fields but are not PT's and it is a mistake to think that they can supervise an aide to yield appropriate PT care for their patients. PT's on the other hand, have years of schooling and continuing education qualifying them to treat all kinds of specialty conditions in their field and subfields of expertise. Submitted by Mary Rosenberg PT, CLT-LANA

Submitter : Dr. David Namazy **Date & Time:** 09/17/2004 09:09:39

Organization : Dr. David Namazy

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

REGARDING REDUCTION OF RVU FOR THE CODE 36870 (percutaneous thrombectomy). I am a nephrologist in San Diego and am greatly concerned about the proposed reduction in non facility RVUs for the abovementioned code. My dialysis patients require a patent arteriovenous access to continue dialysis and therefore sustain life(these sometimes require removal of thrombus). We have streamlined this to an office procedure in a Fluoroscopic suite which has given my patients a much improved quality of life (instead of frequent hospitalizations).These are technically difficult procedures in a group of extremely ill patients. There has been no reduction in cost, or effort in performing an outpatient thrombectomy so I cannot understand the reduction in RVU. I URGE YOU TO PLEASE RECONSIDER THIS AND PLEASE ADJUST THE RVUs PRIOR TO THE FINAL RULE.
Thank you for your attention
David S. Namazy, MD
Balboa Nephrology Medical Group

CMS-1429-P-1912

Submitter : Pat Carter **Date & Time:** 09/17/2004 09:09:50

Organization : Pat Carter

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I would urge support of this issue to prevent unqualified personnel from performing Physical Therapy treatments and then billing it as physical therapy. I definitely feel that it is in the patient's best interest to have a PT or PTA under the supervision of a PT, provide the necessary and appropriate services. This would certainly help decrease the chances of overutilization of services, overcharges, and provide the patient with the most knowledgeable person as the provider.

CMS-1429-P-1913

Submitter : Mr. Paul Manwaring **Date & Time:** 09/17/2004 09:09:34

Organization : Connecticut Athletic Trainers' Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-1913-Attach-1.doc

Attachment #1913

August 24, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- "Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments, education, and needed immediate therapeutic interventions elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, and this will take away from the physician's ability to provide the best possible patient care.

- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor's or master's degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Athletic training academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT). CAAHEP is the same body which provides accreditation review for physician assistant education programs and other allied health care educational programs.

- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide "incident to" outpatient therapy in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- The therapeutic 9700 CPT codes are *NOT* provider specific and can be utilized by all qualified health care providers with the exception of provider specific evaluation and re-evaluation codes. The American Medical Association did not intend these therapeutic codes for only select providers. When used appropriately, these codes are very specific and designate specifically, what services have been provided to the patient under the care of the physician.

- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional

group who would seek to establish themselves as the sole provider of therapy services.

- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.***

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

- If CMS is determined restrict the physician's scope of professional practice and who is qualified to bill for therapeutic services under a physician for the active Medicare population, then it must also list the Certified Athletic Trainer (ATC) who has long treated this population in partnership with physicians

- In regards to PTA and OTA supervision, both should be directly supervised by their respective parties. ATCs possess a higher level of education and training in providing therapy services, consisting of an advanced degree, the minimum of a BS from an accredited educational four-year college or university, with over 70% of Certified Athletic Trainers holding a MS degree, versus PTAs and OTAs who only are required to have a two-year AA or associates degree. In addition, all ATCs are required to be directly supervised when providing incident to therapy services. PTAs and OTAs should be held to the same standard of supervision.

    - Specifically, **all three incident to health care providers and others deemed qualified by the physician** to provide therapy services (ATCs, PTAs, and OTAs) should be permitted provide incident to therapy services to Medicare patients, either under a physician or their respective supervising parties.
    - Again, *since 1991 ATCs have been considered by the **American Medical Association** to be a health care provider of therapy services*

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Respectfully,

Paul Manwaring
Assistant Athletic Trainer
Central Connecticut State University

CMS-1429-P-1914

Submitter : Mr. James Love **Date & Time:** 09/17/2004 09:09:43

Organization : Mr. James Love

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

To whom it may concern,

This comes in regard to the "incident to" bill currently being considered by CMS. Failure to pass this bill would be a major mistake for our health care system.

You must put a stop to reimbursement for untrained personnell providing "therapy" services under the direction of a physician. The current practice is not only dangerous but costly. Allowing physicians to bill for "treatments" provided in their clinic by untrained personnel is supportive of self-referral and contradictory to the Stark bill. Physicians support the current practice because it lines their pockets without additional work on their part. Hence, increased cost to the system. Would CMS consider allowing physicians to sell prescription drugs to medicare recipients? Then why allow them to "sell" therapy treatements in the same manner. It is dangerous in that the untrained personnel hired by physicians to perform these "incident to" services are often undereducated in treating the Medicare population. Physical therapists, occupational therapists, and assistants to both are the only qualified professionals to provide physical medicine to these patients. They are the only ones with the educational background in geriatric rehabilitation. Physical and occupational therapists understand not only the physical treatment aspect but also the neurological and pathological as well. Athletic trainers may have you believe that they are well qualified to treat medicare patients, however, they lack the neurological understanding required. They also lack expertise in co-morbidities present in the elderly population. Athletic trainers' education is in fit athletic peoples. While some of the geriatric population is fit and athletic, much is not. Is CMS prepared to grant a profession that is capable of treating only a small number of its beneficiaries permission to treat its entire population? Does CMS really think that the physician is going to be standing right there while this untrained person places the health of the patient at risk? Also how does the physician know how best to rehabilitate the patient? That is not their area of expertise. Physicians are masters of medication, surgery, and pathology...not rehabilitation techniques. So how do they direct an untrained person, when they themself may not know how to treat the patient?
Finally, let me say that I am both a physical therapist and a certified athletic trainer. My BS in in athletic training and then I went on to get a Master's degree in PT. I can attest to the knowledge base of both professions. Athletic trainers have no business being allowed to treat medicare patients. An ATC could treat a healthy TKA patient but not the one with COPD, CHF, or Parkinson's. Let's all be realistic and admit that physical therapists, occupational therapists and their respective assistants are the only true professionals educated to provide the most efficient, safe and cost effective treatment to medicare patients.

Sincerely,
James M. Love, PT, MPT, ATC/L

Submitter : Mr. Marcus Homer **Date & Time:** 09/17/2004 09:09:16

Organization : William Woods University

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attatched file

CMS-1429-P-1915-Attach-1.doc

Attachment #1915

Marcus Homer MSEd, ATC/R
One University Avenue
Fulton, MO 65251

9-17-04

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Marcus Homer

CMS-1429-P-1916

Submitter : Robert White **Date & Time:** 09/17/2004 09:09:25

Organization : Certified Athletic Trainer

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

As a certified Athletic Trainer,I feel that I am highly qualified to provide on-site rehabilitation services,home instruction and lifestyle/fitness routines as directed by a physician to alleviate or treat an illness or injury. It is insulting to my profession to think that the federal government doesn't consider certified athletic trainers qualified to care for our senior population!

CMS-1429-P-1917

Submitter : Blain Empey **Date & Time:** 09/17/2004 09:09:30

Organization : Blain Empey

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a physical therapist and certified athletic trainer. I support the position of the NATA (see attached letter). I believe the APTA is ignoring the certified athletic trainer's experience and education as a type of 'turf' battle. Please support the NATA and it's position and do not pass legislation which will limit other professionals. Thank you.

Submitter : Ms. Cheryl Blauth **Date & Time:** 09/17/2004 10:09:48

Organization : Hamline University

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file. Thank you

CMS-1429-P-1918-Attach-1.doc

Attachment #1918

Cheryl Blauth, ATC
1697 Minnehaha Ave west, APT 3
St. Paul MN 55104

September 17, 2004
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:
I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.
During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays

of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Cheryl Blauth, ATC
1697 Minnehaha ave west, APT 3
St. Paul, MN 55104

Submitter : Ms. helaine markowitz **Date & Time:** 09/17/2004 11:09:00

Organization : tina treasure,s

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Dme products. Mastectomy products should be excluded from the face to face prescription requirements. Effects of mastectomy are permanent & necessary throughout her life. Medicare has parameters in place regarding these items. Requiring face to face will place undo burden to all parties involved and additional cost to Medicare.

CMS-1429-P-1920

Submitter : Mr. Chris Christensen **Date & Time:** 09/17/2004 11:09:45

Organization : Dominican Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

September 17th 2004

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P Re: GPCI
P.O. Box 8012
Baltimore, MD 21244-8012

CMS Code 1429-P

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

Please reconsider your proposed rule. CMS committed in 1996 to updated the physician payment localities if there has been a significant change in practice costs. Santa Cruz County remains the most disadvantaged county in California. The payment differential for physician services in a county less than 20 miles from our business is over 25% greater than for services performed by local physicians. I understand that this is by far the greater such differential in the country.

This needs to stop. We are losing doctors and important specialties. Our organization cannot fathom how this is allowed to continue. I believe that Congress has delegated to CMS the responsibility to manage the payment to physicians. Further, we believe that no other county in the U.S. is in greater need of reform than our county. It is your responsibility to correct this problem. Continued postponement of this long-needed reform is ill advised and inappropriate.

Health care costs are high in our community. The economy of this county is entirely equivalent to Santa Clara County. Housing costs, wages, and benefits are equivalent. How can you support the payment differential as you propose in your rule? How can you continue to include counties such as Santa Cruz, Sacramento, and San Diego in the rural Locality 99 designation? We understand that Congress is directing to include our county in a federally sponsored redistricting in 2005. This needs to occur now.

Sincerely,

Chris Christensen MPT, CSCS
Physical Therapist and Certified Strength & Conditioning Specialist
Santa Cruz Sports Medicine Center
(831) 457-7099

CMS-1429-P-1921

Submitter : Mr. Craig Hackett **Date & Time:** 09/18/2004 12:09:03

Organization : NATA, Eastern AZ College, Roadrunner Rehab Inc.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Centers for Medical Services, Dept of Health and Human Services
Attention CMS-1429-P, PO Box 8012, Baltimore, MD 21244-8012
"Therpy Incident to"
I am outraged that Athletic Trainers are being considered less than any other healthcare professional. I have nearly ten years of successful practice as an Athletic Trainer I have never been considered less than an equal by my fellow employees or my boss all of whom are physical therapists. I have in many cases been assigned patients by doctors, specifically for my skills developed because of my training as an athletic trainer and honed through years of on field and in clinic practice. Why should I be denied the same right to bill for compensation as any other licensed professional? I have superior schooling, I have passed a challenging national exam and continue to receive education in order to maintain my license to practise. Please do not allow a few greedy, insecure groups deny me the right to practise the occupation I love and which serves my community in a postive, helpful, and healing way. Thank you, Craig Hackett, ATC,L. Safford Arizona, USA.

Submitter : Mr. James Grant **Date & Time:** 09/18/2004 01:09:45

Organization : St. John Fisher College

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

CMS-1429-P-1922-Attach-1.doc

Attachment #1922

James M. Grant, ATC
4 Meadows End
Webster, NY 14580

September 20, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy-Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- "Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered.

- There have never been any limitations or restrictions place upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interest of the patients.***

- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor's or mater's degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapist, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

- To allow *only* physical therapist, occupational therapist, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide "incident to" outpatient therapy in physicians' offices would improperly remove states' rights to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS,***

at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers accompanied the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race goes to their local physician for treatment of that injury is outrageous and unjustified.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

James M. Grant, ATC

Submitter : Mr. Jimmy Leung **Date & Time:** 09/18/2004 01:09:08

Organization : Independent

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 17, 2004

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1429-P

P.O. Box 8012

Baltimore, MD 21244-8012

Re: Therapy ? Incident To

To whom it may concern:

As a future patient, I feel compelled to write this letter in opposition of proposal CMS-1429-P. This proposal limits patient access to qualified health care providers of ?incident to? services, such as ATCs and others, in physician offices and clinics; thereby, reducing the quality of health care for physically active patients. Furthermore, limiting access to qualified health care providers causes health care delivery delays, which increase health care costs and taxes an already over burdened health care system.

Athletic trainers are health care professionals recognized by the American Medical Association. They specialize in the prevention, assessment, treatment and rehabilitation of injuries to athletes and others engaged in physical activity. Athletic trainers are multi-skilled health care professionals who make significant contributions to health care. ALL certified or licensed athletic trainers must have a bachelor?s or master?s degree from an accredited college or university. A great majority (70%) of practitioners hold advanced degrees comparable to other health care professionals, including physical therapists, registered nurses, and speech therapists.

Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America. Dozens of athletic trainers served with the U.S. Olympic Team in Greece to provide health care services to our top athletes. For CMS to even suggest that athletic trainers are unqualified is outrageous and unjustified. Independent research demonstrates the quality of services provided by athletic trainers is equal to physical therapists.

?Incident to? has, since 1965, been utilized by physicians to allow others, with physician supervision, to provide services as an adjunct to the physician?s services. A physician has the right to delegate patient care to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and qualified. There have never been restrictions in terms of who can provide ANY ?incident to? service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the physician?s professional judgment to determine provider qualifications of a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

If this proposal would pass, it would threaten the employment of many athletic trainers who are employed as physician extenders in clinics and physician offices. Therefore this proposal threatens my future and the value of Athletic Trainers. With this type of limitation artificially placed on the provision of ?incident to? services by qualified (through accredited academic programs in athletic training, a national board examination, and state practice acts) health care providers the CMS will only add to the skyrocketing health care costs, put qualified people out of work, and reduce the overall quality of health care in the United States.

In summary, CMS offers no evidence of a problem and the CMS-1429-P proposal must be rejected. This appears as an effort to appease a single professional group who seeks to establish themselves as the sole provider of therapy services. The proposed changes are unjustified, not necessary and will diminish health care in the US.

Sincerely,

Jimmy Leung

Submitter : Mr. Trevor LeDain **Date & Time:** 09/18/2004 03:09:52

Organization : University of Montana

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

To Whom it May Concern:
To ensure patient safety and quality of care that is described to the patient as "physical therapy", I strongly support the rule change that would help prevent unqualified people from practicing and performing physical therapy modalities and interventions.
Thank you, Trevor LeDain, SPT

CMS-1429-P-1925

Submitter : Ms. michael Mckenney **Date & Time:** 09/18/2004 05:09:17

Organization : National Athletic trainers association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

To Whom it may concern,

My name is Mike McKenney and I am a licensed and certified athletic trainer. I currently work in a professional clinical setting where I have the opportunity to work with many patients and athletes of all levels. Including some of the worlds top professional athletes like Randy Johnson and Terrel Davis.

Athletic trainers are academically qualified (70%holding a Master's degree or higher) and clinically qualified to provide outpatient rehabilitation services for athletic injuries under the supervision of a physician. It is both false and insulting to suggest otherwise.

If doctors and the worlds top athletes trust athletic trainers, so should you. We are here to help the world, not just athletes.

Sincerely,
Mike McKenney MS, ATC/L

CMS-1429-P-1926

Submitter : Mr. Ryo Tahara **Date & Time:** 09/18/2004 05:09:19

Organization : Mr. Ryo Tahara

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

This letter is written in regards to a recent proposal by your organization, The Centers for Medicare and Medicaid Services, involving athletic trainers. The charges your organization is proposing would prevent renbursment by Medicare or Medcaid for rehabilitative services provided by a certified athletic trainer under the supervision of a physician, in a clinical setting. Not only will this limit the physician's ability to choose an appropriate health care provider for their patients, it will also interfere with the patient's ability to receive competent, professional quality healthcare from individuals trainers and specialized in this area.

Certified athletic trainers are qualified to perform a variety of rehabilitative services within a wide array of setting, both clinical and non-clinical. They are trained extensively in numerous on and off-the-field evaluatives techiniques which provide them with a strong basis for providing excellent therapeutic services.

The clinical education experiences of an athletic trainer are extensive and are in some cases much more involved then those of Physical Therapy Assistants or Occupational Therapy Assistants, who under your proposed changes would still be convered by Medicare and Medicaid to perform services under a p hysician. In fact, according to the Federal Gorvernment, preparation for certification as an athletic trainer is equivalent to that of a physical therapist, and the rating for level of education, preparation required and duties perform by an athletic trainer according to the United States Department of Labor is higher then that of Occupational Therapy and is significantly higher than the rating for Occupational Therapy Assistants and Physical Therapy Assistants. In addition, athletic training students are often required to take many of the same classes as are physical therapy students, and are trained specifically in programs in areas of pathology of injuries and illness, recognition, evaluation and assessment of injuries, tretment, rehabilitation, and reconditioning, therapeutic modalities, and therapeutic exercise.

The certification process for an athletic trainer allows themt o work in a variety of setting including in a physicin's office providing therapy for patients. An athletic trainer who is certified by the National Atheletic Trainers Association (NATA) is a highly qualified paramedical professional, educated and experienced in dealing with injuries. Candidates for certification are required to have an extensive backgroud of both formal academic preparation and supervised practical experience in a clinical setting.

It is because of these above mentioned reasons that I am asking you to reconsider your proposal to prohibit reinbursement by Medicare and Medicaid for services providing by a certified athletic trainer. It is in the best interests of the patients across the United States seeking qualified individuals to aid in their healthcare and rehabilitation that you do so. We as healthcare professionals should seek to further cooperate to achieve our goals of helping the peoepl who seek our aid.

Submitter : Dr. Kimberly Peer **Date & Time:** 09/18/2004 09:09:49

Organization : Kent State University

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

CMS-1429-P-1927-Attach-1.doc

Attachment #1927

Kimberly S. Peer, Ed.D., ATC, LAT
Kent State University
Kent, OH 44242

September 17, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care.
- This country is experiencing an increasing shortage of credentialed allied health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence - by all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. For CMS to even suggest that athletic trainers are unqualified to provide these same services is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. Sincerely,

Kimberly S. Peer, Ed.D., ATC, LAT
Kent State University
Kent, OH 44242

CMS-1429-P-1928

Submitter : Dr. YuChou Shen **Date & Time:** 09/18/2004 11:09:50

Organization : APTA of MA

Category : Physical Therapist

Issue Areas/Comments

Issues 10-19

DEFINING THERAPY SERVICES

It is my opnion that if Medicare wants to increase anybody's bottom line, it should be Medicare beneficiaries. There is little argument about why physical therapyists are the best trained provider to provide physical therapy. However, by allowing unqualified practioner providing physical therapy under the license of a physician, it compromises the quality of physical therapy delivered. Medicare has shown in many aspects in the past that it wants its beneficiaries to recevie proper service at the right price. By allowing unqualified practioner practicing physical therapy under physician's "umbrella", medicare is paying a decent fee for substandard services. It does not make common sense nor money sense. Medicare should consider if allowing unqualified practitioner to practice physical therapy makes any sense besides jeopardizing its beneficiaries' services received? I belive medicare beneficiary would be more happy to know that practioners who provide them services under medicare guidelines are qualified in ther field of their practice, not someone "incident to" work in their physician's office.

CMS-1429-P-1929

Submitter : Dr. Woodworth Clum **Date & Time:** 09/18/2004 11:09:47

Organization : Emergency Medical Group

Category : Physician

Issue Areas/Comments

Issues 1-9

GPCI

September 2004

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS Code 1429-P

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

I object to the Proposed Geographic Practice Cost Indices for 2005 because they fail to correct proven inadequacies in reimbursements to localities currently categorized as "Locality 99" that exceed the 5 percent threshold (the "105% rule") over the national 1.000 average. Specifically, the new GPCIs exacerbate reimbursement deficiencies for the California counties of Santa Cruz, Sonoma, Monterey, San Diego, Sacramento, Santa Barbara and El Dorado.

In particular, the county of Santa Cruz, when broken out from Locality 99, would otherwise reflect a 1.125 percent GAF - higher than the California Localities 17 (Ventura), 18 (Los Angeles) and 26 (Orange). The boundary payment difference between Santa Cruz County and its neighboring county of Santa Clara (Locality 9) is a whopping 25.1 percent. Such statistics demonstrate the fallacy of the GPCI formula and demand CMS develop either exceptions to the current rules that would correct for the Santa Cruz situation or refine the formula to more accurately reflect the true cost of medical practitioners. Not to do so perpetuates an inherently unfair and discriminatory formula.

In its August 5 notice, CMS states that on the issue of payment localities "[a]ny policy that we would propose would have to apply to all States and payment localities." Such an effort is commendable and bespeaks a desire to be fair to all physicians across the nation. However, the reality is that the governing statute does not prohibit individual State fixes or individual county or locality fixes. The CMS is not constrained by law from developing a strategy - with or without the concurrence of the state medical association - to correct the discrepancies in the reimbursement levels to California counties and I request that it do so as part of this rulemaking process.

CMS cannot postpone a solution this year as it did last year. Failure to address the GPCI/locality issue in California only grows the problems and will make fixing it all the more difficult in the future. Further, it threatens to undermine medical care to Medicare beneficiaries. Evidence from the local medical society shows an increasing trend toward doctors refusing to accept new Medicare patients. Many doctors are simply leaving the county to practice elsewhere, depleting the county of its medical resources. To implement the August 5 proposed rules would be counterproductive to CMS' mission to make Medicare benefits affordable and accessible to America's seniors.

I object to the Proposed Geographic Practice Cost Indices for 2005 as printed in the Federal Register of August 5, 2004. I request that CMS define

a method in which it can revise the GPCIs for those California counties - especially Santa Cruz - that exceed 5 percent of the national average and begin reimbursing doctors in those counties more appropriate to their true costs.

Sincerely,

Woodworth B Clum, MD
Emergency Physician
Watsonville Comm. Hosp.
Watsonville, Ca 95076

CMS-1429-P-1930

Submitter : Mr. Mark Hanak **Date & Time:** 09/18/2004 12:09:51

Organization : National Athletic Trainers Association

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

"Please see attached file"

CMS-1429-P-1930-Attach-1.doc

Attachment #1930

September 18, 2004,
Centers for Medicare & Medicaid Services
Department of Health and Human Resources
Attention: CMS-1429-P

P.O. Box 8012
Baltimore, Maryland 21244-8012

COPY FOR: REP. J. KINGSTON

Re: Therapy- "Incident-To"

To Whom It May Concern:

I would like to reiterate the sentiments of a fellow United States government co-worker at the Federal Law Enforcement Training Center, when I say that I am appalled that CMS would even entertain, much less, be coerced by the APTA into possibly legislating that only physical therapists provide " incident-to " physical medicine services to Medicare patients in the physicians offices and clinics.

By mandating this proposal, it would in essence be undermining the professional integrity and decision making process of all physicians in their effort to hire the most qualified personnel to treat their patients. This would also give preferential professional advantage to a group who already perceive themselves as the only true providers of physical rehabilitation. Ultimately, the individual selected by the physician to provide the best possible care, whether it is a nurse, a tech, a PTA, an ATC or a PT is the sole responsibility and liability of the attending physician.

"Incident-to" service is a very unique interaction of multiple health care professionals within their sub-specialty in order to provide the optimal health care for their patients. Taking the certified and/ or licensed athletic trainer out of this equation would be eliminating a valuable asset to the physician and a grave disservice to the Medicare patient.

As a practicing certified athletic trainer for the past thirty three years, I have been employed as an Athletic Trainer in the NFL for 8 years, at two major universities, a Fortune 100 company, a Executive Director of two private physical therapy clinics, and I am currently a Senior Athletic Trainer with the Department of Homeland Security at the Federal Law Enforcement Training Center in Glynco, Georgia.

I have a Master's degree, I am Nationally Registered as an EMT-I, have met continuing education requirements for over 30 years and know that I am well educated and qualified and experienced in the sub-fields that comprise the athletic training profession, as well as the use of physical and therapeutic modalities and orthopedic rehabilitation techniques. During my career at the collegiate level, I was entrusted with the care, prevention, treatment, and rehabilitation of many future "million" dollar athletes who have gone on to be very successful in the NFL NBA and NHL.

It is a privilege to be employed by United States Federal Government at this juncture of my career, thereby allowing me to practice the same professional care and expertise on the finest Federal Law Enforcement agents in this country. I am an instructor to some seventy agencies including the US Marshals, US Secret Service, US Customs and Boarder Protection, Alcohol, Tobacco, and Firearms to mention a few in the areas of Basic Life Support, CPR, Injury Management Heat Stress Management, and EMS-AED training as well as the daily care, prevention, treatment, and rehabilitation of these agents during their training. So please do not insinuate or infer that I as a Certified Athletic Trainer am not qualified to treat and or rehabilitate a Medicare patient with my credentials.

The certified athletic trainer is a highly skilled, well educated, allied health care professional accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT), and certified by the National Athletic Trainers' Association. It should also be noted that the American Medical Association officially recognizes the National Athletic Trainers' Association (Certified Athletic Trainers) as allied health care professionals.

I take offense to the APTA's statement that "under current policy it is possible for a high school student or another individual with no training in anatomy, physiology, neuromuscular reeducation or other techniques to furnish services in a physician's office without the physician actually observing the provision of these services." Physical therapists do not have exclusivity to the term "therapy" as defined by Webster as "the treatment of illness or disability" just because it happens to be in their job description/title. A therapist is a "specialist in conducting therapy" and not solely a physical therapist. With this being said, I would like to pose a question and make a statement for the CMS to ponder. How can the CMS even entertain this proposal of "incident-to" care involving certified athletic trainers when in physical therapy clinics all across this country physical therapy aides are hired everyday with little more than a high school education and with little or **NO** prior knowledge of anatomy, physiology, neuromuscular reeducation, or therapeutic exercise. However, this unlicensed, unqualified, and unsupervised aide is allowed to oversee Medicare patients during therapeutic exercise while the physical therapist on record is many times in a private room treating another patient and billing for both patients. This is a total contradiction to quality patient healthcare as advocated by the APTA through the utilization of these unqualified personnel.

As I perceive this whole “incident-to” issue involving athletic trainers, it appears to be just another ploy by the APTA and physical therapists to monopolize the therapeutic care of the Medicare patient population. It has nothing to do with quality patient health care or the “unlicensed personnel who have not graduated from an accredited physical therapy professional program,” it has to do with revenue and potential lost revenue.

In closing, let the system work, provide for the Medicare patient and be advised (the baby boomers are fast becoming the largest medical patient population and I am of that generation), and to that I will be dependent on the CMS for assistance. Let the physicians be responsible in seeking the best most qualified individuals for their patients medical care and do not allow a self serving group such as the APTA dictate government policy.

Thank you,

Mark P. Hanak MS, ATC, EMT-I
Senior Athletic Trainer
Department of Homeland Security
Federal Law Enforcement Training Center
Glynco, GA 31524

CMS-1429-P-1931

Submitter : Miss. Amy Beckman **Date & Time:** 09/18/2004 12:09:24

Organization : National Athletic Trainers Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

*Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
*There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
*In many cases, the change to ?incident to? services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
*This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working ?incident to? the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
*Patients who would now be referred outside of the physician?s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient?s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
*Curtailing to whom the physician can delegate ?incident to? procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician?s ability to provide the best possible patient care.
*To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide ?incident to? services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide ?incident to? care in physicians? offices would improperly remove the states? right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

CMS-1429-P-1932

Submitter : Ms. THERESA SCHMIDT **Date & Time:** 09/18/2004 01:09:07

Organization : FLEX PT

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

All services provided in physicians office must be provided by competent qualified licensed physical therapists or PT Assistants supervised by PTs. Currnetly, you are paying for nonqualified aides at rates set for licensed PTS. This is APPALLING. My taxes should not be paying for personnel to treat patients who hve NO training when my practice is severely limited and I have a Masters degree in PT, as well as Board Certification as a specialist. Why do you pay the same or greater fees to doctors who hire foreign unqualified kids to provide what they bill as "physical therapy" when they do not even see what is done, they are not even present in the room, and patients are subject to injury because these kids do not have any qualifications to treat. It is a financial scam that CMS continues to pay for so our taxes go to the doctors' pockets.
STOP paying for nonqualified people who are billing under the auspices of a physician for so-called physical therapy. People are being injured and also are under the impression that a kid putting a TENS unit on a patient with no experience is giving themn PT. It is JUST PLAIN WRONG!
Only skilled PT / PTA providers should be paid for PT services.
Save the system a great amount of money by limiting payment to REAL licensed professionals! (Not charlatans who are abusing the system billing unskilled services.)

CMS-1429-P-1933

Submitter : Dr. Kumud Tripathy **Date & Time:** 09/18/2004 02:09:13

Organization : Cancer Clinic

Category : Physician

Issue Areas/Comments

Issues 1-9

PRACTICE EXPENSE

I am a Medical Oncologist and administer chemotherapy in my office. Under the proposed CMS rules, my drug cost (price that I must pay to my supplier) will be very close to the amount of Medicare reimbursement. I buy close to 4-5 million dollar worth of drugs and supplies (please note supplies are not paid by Medicare) each year. Please name me a business that will buy products for 5 million dollars, and sell it to clients HOPING to recoup, in the best-case scenario, it's capital outlay of $5million. Unlike The Airlines and grocery Stores, I don?t get paid at the time I ?sell? my product. Instead, I spend 5 million dollars to buy the product, store it and ?sell? with EXPECTATION that I will be reimbursed by a THIRD PARTY in 4-12 weeks after answering a lot of burocratic questions, appeals and re-appeals. At times things get lost in the shuffle and we don't get paid at all. More often, we get only a part of the payment for reasons such as the secondary insurance runs out, does not exist or just refuses to pay and patients don't have money to cover 20% of $250,000 which these days is the drug cost of treating a metastatic Colon Cancer. How long do you think a business can last under this payment? I hope you get the picture.

Kumud S Tripathy, M.D.

CMS-1429-P-1934

Submitter : carol buono **Date & Time:** 09/18/2004 02:09:33

Organization : just for you two mastectomy boutique

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

mastectomy products should be excluded from face to face rx requirements because the effects of a mastectomy are permanent.

CMS-1429-P-1935

Submitter : Mr. Patrick Zerr **Date & Time:** 09/18/2004 03:09:11

Organization : Summit Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am in support of the proposed revisions. Physical therapy / rehabilitation services should be provided by a licensed physical therapist or assistant. There are other providers who have knowledge of modalities and therapeutic exercise, but do not have the knowledge of how to apply the modalities depending on the pathophysiology that often exists.
Many Medicare patients have more than usual complications due to age and pathology that accompanies the aging process. Athletic trainers, personal trainers, chiropractors, exercise physiologists do not have the type of training or education to treat these clients, or assess the effect of such treatments on their conditions.

I am most concerned about the use of non-licensed care by under the supervision of a physician. Most of the time a physician does not understand the scope of my practice and I have to educate them on the appropriate or non-appropriate use of a treatment. I am afraid that improper use of rehabilitation techniques is to the detriment of Medicare recipients. It is an injustice because although they have the ability to bill for these services they do not have the education themselves to prescribe the appropriate treatment. The supervision of non-licensed practitioners leads to now 2 poorly capable providers to deliver the care of physical therapy services! Nonetheless these physicians who are supervising treatment are not held to the same guidelines that physical therapists are, which is to be immediately available within line of sight type of supervision.
I hope the CMS does not succumb to the pressures from other providers. If it would be that easy for physical therapists to become educated in their field why is there so much emphasis on accrediting the schools and sitting and passing a national exam for licensing by each state's medical board of physical therapy!?

THERAPY STANDARDS AND REQUIREMENTS

Physicians, Chiropractors, Exercise Physiologists, Athletic Trainers, Personal Trainers, Massage therapists, nursing aides, and many others do not have the education or experience to capably apply principles of physical therapy to Medicare recipients.

There are special needs that each of the groups mentioned above do not have training to provide the basic billing codes/services to. For example: Childhood neurological diseases, Spinal Cord Injuries, Brain Injuries, Amputations, Stroke Injuries, just to name a few.

Physical Therapists gain specific knowledge regarding the pathophysiology and treatment for these conditions. Please refer to the specific training of the above groups for what type of training these people gain through education and then how are they tested for examination to become licensed. Does their licensure exam address the above pathologies and treatment types?
I strongly suggest they do not and therefore lies the reason for physical therapists to be the only providers of such services!

CMS-1429-P-1936

Submitter : Keven F **Date & Time:** 09/18/2004 04:09:14

Organization : Student PTA

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September, 18, 2004

Mark B. McClellan, MD, Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Subject: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005.

Dear Dr. McClellan:

Regarding the "Therapy-Incident To" language per CMS-1429-P, I would like to strongly voice my support for CMS's proposed requirement that physical therapists working in physicians offices be graduates of accredited professional physical therapist programs.

As a student PTA, I have direct exposure and education of physical therapy services, not limited to studies of human anatomy + physiology, therapeutic exercise and a variety of modality techniques. A lack of knowledge in any of these areas by an unqualified practitioner poses a serious health risk to any patient, and no doubt a variety of malpractice cases to follow.

It is easy to blur areas of discipline and presume exercise physiologists, athletic trainers, and kinesiotherapists have the necessary skills to competently perform physical therapy services in a physician?s office, but that?s not the case. Those areas of expertise are focussed to serve specific patient populations. Would an athletic trainer know how to treat a CVA patient with NMES?Probably not. Or would an exercise physiologist know the contraindications for using therapeutic ultrasound on the pediatric population? Again, probably not.

With respect to the Medicare therapy cap scheduled for January 1, 2006, patients who receive physical therapy services by non-PT?s or non-PTA?s, could reach their benefit level prematurely at substandard care. Should future physical therapy services be required by an actual PT or PTA after a patients cap has been reached, the patient will either need to pay for services out-of-pocket, not pay, or simply refuse physical therapy. There are two solutions to this problem: 1) Raise the Medicare cap on PT benefits and/or 2) guarantee that Medicare patients who require PT reach there PT goals in the fewest visits needed, by being treated with the best care through a degreed/licensed PT or PTA and no one else.

Thank you for your consideration of these comments.

Sincerely,

Keven F.
Student, Physical Therapist Assistant
Cleveland, OH 44139

CMS-1429-P-1936-Attach-1.doc

Attachment #1936

Keven F.
Student, Physical Therapist Assistant
Cleveland, OH 44139

September, 18, 2004

Mark B. McClellan, MD, Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Subject: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005.

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As a student PTA, I have direct exposure and education of physical therapy services, not limited to studies of human anatomy + physiology, therapeutic exercise and a variety of modality techniques. A lack of knowledge in any of these areas by an unqualified practitioner poses a serious health risk to any patient, and no doubt a variety of malpractice cases to follow.

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Thank you for your consideration of these comments.

Sincerely,

Keven F.
Cleveland, Ohio 44139

Submitter : Ms. Donna Langford **Date & Time:** 09/18/2004 03:09:31

Organization : A New Image

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Regarding the proposed face-to-face prescription requirements. We have been dealing with mastectomy patients and their needs for almost 40 years. We do not believe that the ladies should be subjected to further emotional upset by the requirement of having to go to see a doctor in order to obtain permission to purchase a product that she will have to use for the rest of her life. After the surgery her surgeon and doctor have already certified that she is in need of the specialized mastectomy products. No woman would purchase a prosthesis unless she really needed it. Having to ask for these products just serves to reinforce her loss and possibly could have a detrimental effect on her self esteem. It could end up costing both the patient and medicare more money - the doctor will submit a claim for the office visit to medicare and the patient will have the cost of an extra office visit co-pay. (Over the years we have heard of doctors who charge a $75 office visit fee for the ladies to obtain a presription for the prosthesis and mastectomy bras.)

CMS-1429-P-1938

Submitter : Dr. Myron Bednar **Date & Time:** 09/18/2004 03:09:52

Organization : Hunterdon Hematology Oncology, LLC

Category : Physician

Issue Areas/Comments

Issues 1-9

SECTION 303

As practicing medical oncologists in New Jersey, we are very concerned about the proposed policy to chemotherapy drug reimbursement.

The AWP system was introduced to accommodate the treatment of cancer patients in the outpatient setting. Patients have been allowed to lead normal lives while receiving chemotherapy. Over the years reductions in reimbursement for services and the bundling of codes was supplemented by drug revenue. Oncology practices adjusted to these changes.

The proposed changes now substantially reduce drug reimbursement without adequately covering associated expenditures.

We have assessed the impact of this change on our practice. We will be unable to purchase the drugs and supplies at the projected ASP amounts. This will profoundly affect the quality of care for cancer patients.

We are aware that the way the data was collected for the ASP figures had several serious flaws. It will be difficult for us to manage our practice and adjust to manufacturers price increases prior to adjustments from CMS. We have had a 5% & 6% price increase on two major drugs last week. These price increases have taken immediate effect. Reimbursement changes should do the same.

Precedence has shown that the private payors will follow CMS rulings. Medicare and non-Medicare patients will be required to be treated in the hospital. This will have tremendous implications for hospitals as well as patients.

At this time we are requesting that a hold be placed on the proposed changes by leaving the 2004 decision in place while we continue to work with ASCO, COA and CMS to resolve this issue without jeopardizing the future of cancer care.

Submitter : Dr. Kenneth Blankstein **Date & Time:** 09/18/2004 04:09:34

Organization : Hunterdon Hematology Oncology, LLC

Category : Physician

Issue Areas/Comments

Issues 1-9

SECTION 303

As practicing medical oncologists in New Jersey, we are very concerned about the proposed policy to chemotherapy drug reimbursement.

The AWP system was introduced to accommodate the treatment of cancer patients in the outpatient setting. Patients have been allowed to lead normal lives while receiving chemotherapy. Over the years reductions in reimbursement for services and the bundling of codes was supplemented by drug revenue. Oncology practices adjusted to these changes.

The proposed changes now substantially reduce drug reimbursement without adequately covering associated expenditures.

We have assessed the impact of this change on our practice. We will be unable to purchase the drugs and supplies at the projected ASP amounts. This will profoundly affect the quality of care for cancer patients.

We are aware that the way the data was collected for the ASP figures had several serious flaws. It will be difficult for us to manage our practice and adjust to manufacturers price increases prior to adjustments from CMS. We have had a 5% & 6% price increase on two major drugs last week. These price increases have taken immediate effect. Reimbursement changes should do the same.

Precedence has shown that the private payors will follow CMS rulings. Medicare and non-Medicare patients will be required to be treated in the hospital. This will have tremendous implications for hospitals as well as patients.

At this time we are requesting that a hold be placed on the proposed changes by leaving the 2004 decision in place while we continue to work with ASCO, COA and CMS to resolve this issue without jeopardizing the future of cancer care.

CMS-1429-P-1940

Submitter : Dr. Brian Quinn **Date & Time:** 09/18/2004 04:09:51

Organization : Hunterdon Hematology Oncology, LLC

Category : Physician

Issue Areas/Comments

Issues 1-9

SECTION 303

As practicing medical oncologists in New Jersey, we are very concerned about the proposed policy to chemotherapy drug reimbursement.

The AWP system was introduced to accommodate the treatment of cancer patients in the outpatient setting. Patients have been allowed to lead normal lives while receiving chemotherapy. Over the years reductions in reimbursement for services and the bundling of codes was supplemented by drug revenue. Oncology practices adjusted to these changes.

The proposed changes now substantially reduce drug reimbursement without adequately covering associated expenditures.

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Precedence has shown that the private payors will follow CMS rulings. Medicare and non-Medicare patients will be required to be treated in the hospital. This will have tremendous implications for hospitals as well as patients.

At this time we are requesting that a hold be placed on the proposed changes by leaving the 2004 decision in place while we continue to work with ASCO, COA and CMS to resolve this issue without jeopardizing the future of cancer care.

CMS-1429-P-1941

Submitter : Julie Moore **Date & Time:** 09/18/2004 04:09:12

Organization : Hunterdon Hematology Oncology, LLC

Category : Physician Assistant

Issue Areas/Comments

Issues 1-9

SECTION 303

We are very concerned about the proposed policy to chemotherapy drug reimbursement.

The AWP system was introduced to accommodate the treatment of cancer patients in the outpatient setting. Patients have been allowed to lead normal lives while receiving chemotherapy. Over the years reductions in reimbursement for services and the bundling of codes was supplemented by drug revenue. Oncology practices adjusted to these changes.

The proposed changes now substantially reduce drug reimbursement without adequately covering associated expenditures.

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We are aware that the way the data was collected for the ASP figures had several serious flaws. It will be difficult for us to manage our practice and adjust to manufacturers price increases prior to adjustments from CMS. We have had a 5% & 6% price increase on two major drugs last week. These price increases have taken immediate effect. Reimbursement changes should do the same.

Precedence has shown that the private payors will follow CMS rulings. Medicare and non-Medicare patients will be required to be treated in the hospital. This will have tremendous implications for hospitals as well as patients.

At this time we are requesting that a hold be placed on the proposed changes by leaving the 2004 decision in place while we continue to work with ASCO, COA and CMS to resolve this issue without jeopardizing the future of cancer care.

Submitter : Mr. Jason Franklin **Date & Time:** 09/18/2004 04:09:47

Organization : Ohio Athletic Trainers Association

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Please consider the followimng comments when making final decision.

CMS-1429-P-1942-Attach-1.doc

Attachment #1942
September 18. 2004

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
PO Box 8012
Baltimore, MD 21244-8012

Re: Therapy-Incident To

I am writing to express my concerns about the recent proposal that would limit providers of "incident to" services in physician offices and clinics. There are numerous reasons to rule against this proposal, with decreased patient care being the single biggest factor. It would also increase the cost of the care that the patient now receives. Physicians know the value of our service and it would do harm to limit their ability to use Certified Athletic Trainers.

Athletic trainers are necessary because they provide immediate care under the direct supervision of the attending physician. Certified athletic trainers are highly qualified individuals. All ATC's have a Bachelor's Degree with over 70% having a Master's Degree. We have taken courses in anatomy, physiology, biomechanics and pharmacology, just to name few of the program requirements.

By only allowing physical therapists, occupational therapists and speech therapists to be providers for "incident to" outpatient services would improperly provide these groups exclusive rights to Medicare reimbursement. Mandating this would improperly remove the STATES' rights to license and/or regulate the allied health care professions deemed qualified, safe, and appropriate to provide health care services.

The Ohio Physical Therapy, Occupational Therapy and Athletic Training Boards set our State Practice Acts and it does allow for Certified/Licensed Athletic Trainers to provide rehabilitation. Athletic Trainers are recognized and reimbursed for their therapy services by a number of insurance companies, including the Ohio Bureau of Worker's Compensation.

Please consider all matters when making your final decision. Please do not allow one professions desire to "corner the market" outweigh the patients benefits. We provide a valuable service the medical community, please allow us to continue.

Sincerely,

Jason Franklin ATC

CMS-1429-P-1943

Submitter : Miss. Jessica Williams **Date & Time:** 09/18/2004 04:09:30

Organization : Baylor University

Category : Academic

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

CMS-1429-P-1943-Attach-1.doc

Attachment #1943
September 16, 2004

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

To Whom It May Concern:

My name is Jessica Williams and I am currently an Athletic Training Student at Baylor University. It has come to my attention that the Medicare and Medicaid Services are currently trying to pass a proposal that will not allow physicians to be reimbursed for therapy services administered by a certified athletic trainer in a physician's office or clinic. There are several reasons why I believe the approval of this proposal would be detrimental to all insurance companies rather than beneficial, as Medicare and Medicaid believes it will be.

First, I want to define the role of a certified athletic trainer and why an athletic trainer's scope of practice should include physician's offices and other non-athletic locations. A certified athletic trainer has several responsibilities in whatever location they are working in. These responsibilities include prevention, assessment, care, and rehabilitation of all injuries for the physically active. Physically active individuals include those who engage in athletic recreational or occupational activities that require physical skills and utilize strength, power, endurance, speed, flexibility, range of motion, and agility. Therefore, a certified athletic trainer's role and location of practice can be expanded to include not only athletes and athletic training rooms, but all the physically active and any place that will provide service for these people.

Today, more athletic trainers are employed in sports medicine clinics than in any other setting. It is also becoming relatively common for corporations or industries to employ athletic trainers to oversee fitness and injury rehabilitation programs for their employees. The athletic trainer working in this type of environment must also have a sound understanding of the principles and concepts of work ergonomics in order to correctly identify and properly adjust any problems to minimize injuries.

Certified athletic trainers that are employed at physicians' clinics have been trained to deal specifically with sports related injuries and injuries that occur within the physically active population, whereas physical therapists have a much broader patient population that they are qualified to give care to. However, the physical therapist that has not been exposed to the athletic training environment is as inefficient in that setting as is the athletic trainer working with stroke patients in a rehabilitation setting. Thus, the employment of athletic trainers in physicians' clinics, as well as other sports medicine and rehabilitation clinics can be extremely beneficial to all patients.

Education programs and academic curriculum for athletic trainers and physical therapists are also extremely similar. In fact, many students today are receiving the

required amount of hours for certification in both areas so as to increase their level of qualification and give them a wider scope of practice. Both athletic training and physical therapy programs require a certain amount of hours in basic sciences and clinical rotations, with many students of both majors taking classes together. This proves that certified athletic trainers are well qualified to work in clinical settings, as they are receiving a similar education to other health care majors.

Finally, according to federal government definition and regulation, the education, training, and instruction of a certified athletic trainer is equivalent to that of a physical therapist. This rating of preparation is also more significant than that of an OT, OTA, or PTA. So, this proposal would allow less qualified health care professionals to treat patients in clinics, while not allowing a more qualified health care specialist, a certified athletic trainer, to be reimbursed for any kind of treatment or therapy they would provide. If this proposal is passed by CMS, it would only harm the Medicare or Medicaid patient by allowing them to be treated by less qualified health care specialists.

Thank you for considering my view on this important matter, and I hope that you will see why the few explanations I have listed here are enough reason to decline this proposal.

Sincerely,
Jessica Williams
Athletic Training Student
Baylor University

CMS-1429-P-1944

Submitter : Mr. Jess Barsotti **Date & Time:** 09/18/2004 04:09:07

Organization : Boston University Society of Athletic Trainers

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Reader:
I am an athletic training student at Boston University in my junior year as well as a member of the Boston University Society of Athletic Trainers. This letter is in regard to the Centers for Medicare and Medicaid Services proposal which recommends that only therapy given by a physical therapist, physical therapy aide, occupational therapist, or occupational therapy aide in a physician?s office should be reimbursed. At present, a physician can choose any appropriately qualified healthcare professional to provide therapy to Medicare patients. This proposal labels athletic trainers as unqualified to treat Medicare patients. However, the American Medical Association has clearly recognized athletic training as an allied healthcare profession and recommends that every high school in the United States should employ a certified athletic trainer to keep young athletes all over the country healthy and safe. How can athletic trainers be qualified to care for children in high school and not be able to deliver the same quality of treatment to the elderly patients of Medicare? The elderly may be viewed as out of the scope of practice of an athletic trainer because the majority of older adults in America are sedentary. However, the Surgeon General?s report: Physical Activity and Health in Older Adults clearly states that the elderly population can benefit greatly from physical activity and regular exercise. Not only can athletic trainers help to end this unhealthy trend of inactivity, but they are also the only healthcare professionals that can adequately accommodate the need for physical activity into a treatment and rehabilitation program.
Athletes of all ages all over the United States entrust their health and safety to athletic trainers because the scope of athletic training deals with the prevention, recognition, evaluation, treatment, and rehabilitation of injuries of physically active people. Developing a treatment and rehabilitation plan is only one small part of an athletic trainer?s job; whether it is designed to help an injured Olympic athlete to set a new world record or to help the average weekend-warrior work comfortably in the office without pain. Athletic trainers should not be limited to the traditional settings of sports when there is so great a potential to help so many more injured people achieve their goals.

Sincerely,
Jess Barsotti, ATS

CMS-1429-P-1945

Submitter : Mrs. Catherine Langford **Date & Time:** 09/18/2004 04:09:41

Organization : mastectomy survivor

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a 40 year breast cancer survivor and in all those years have never grown a new breast. Surprising??? I do not see the necessity of my having to see a doctor solely for the purpose of obtaining a prescription for a new prosthesis. My prostheses have lasted any where from 2 to 8 years. Why should I have to add the cost of a doctor's visit to get a replacement for one that has developed man-made defects.? My health care costs are astronomical -- I need than to come down - not go up.

Submitter : Ms. Karen Langford **Date & Time:** 09/18/2004 04:09:07

Organization : Ms. Karen Langford

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

My mother is a breast cancer survivor and I have gone thru all of the stages with her. If a mastectomy patient should have a physician like mine it could get very costly -- my physician will only answer one question per visit and at $35 co pay that is a bit out of line!!

Submitter : Mrs. Diana Steele **Date & Time:** 09/18/2004 04:09:57

Organization : Mrs. Diana Steele

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

If I read this properly, if a person who has had breast cancer needs to replace their bra (a daily worn item) or my breast form I would have to go back to the Dr. and have an appointment for them to provide me a prescription for the products to be replaced.

First, this is extremely lengthly process. Sometimes it takes weeks (sometimes months) to get an appointment with a Dr. if there is nothing life threatening wrong with you at the time.

Second, it is much more costly. Their is no need to see the Dr. unless there IS something wrong. When your breast is removed, it doesn't "grow" back.

Third, Women, usually go to the Dr. once per year to see their gynocoloist. They have mamograms as well. These Dr.'s always check the health of the breast area or remaining breast tissue at that time. However, they are not the primary Dr's that would need to issue the prescription for our DME supplies.

So you see, this is additional time and expense for Medicare AND Myself.

Thank you for your considerations

Submitter : Miss. Winkler **Date & Time:** 09/18/2004 04:09:26

Organization : Miss. Winkler

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I do not believe that government officials should have the right to dictate to a patient what kind of treatment they are able to receive. It is the job of the physician to prescribe the proper type of rehabilitation program. If a patient's physician feels that a certified athletic trainer would best aid in a patient's recovery, why should the government force the patient to seek help from a physical therapist? I feel that certified athletic trainers are very capable in assisting physicians and their patient's in a variety of ways. Perhaps if physical therapists, athletic trainers, and physicians could all work together, the patient would greatly benefit. By allowing only physical therapists to work within a physician's office, you are wasting the talents and abilities of other health care providers. Remember, the bottom line should be the patient's health and well-being. If a certified athletic trainer can assist in any way to the rehabilitation of a patient, why shouldn't they help? Certified athletic trainers are more than qualified to help patients outside of the athletic training room and would have a positive influence in any clinical setting.

Submitter : Dr. Robert Borda **Date & Time:** 09/18/2004 05:09:43

Organization : Dr. Robert Borda

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

The primary role of a psychologist (or neuropsychologist) in clinical evaluations should be in the interpretation of data for diagnostic and treatment planning issues. Current Medicare regulations require that the provider also be the sole administrator of the tests; this is analagous to requiring that a radiologist actually administer an MRI. Licensed and qualified psychologists should be permitted to closely supervise trained psychometricians in the administration of tests, freeing the psychologist to devote time primarily to test selection and interpretation.

CMS-1429-P-1950

Submitter : Miss. Jessica Brown **Date & Time:** 09/18/2004 05:09:11

Organization : National Athletic Trainers Association

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attched file.

CMS-1429-P-1950-Attach-1.doc

Attachment #1950

Jessica L. Brown, ATC
260 N. Stephora Ave.
Covina, Ca, 91724

September 17, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be

forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes

from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Jessica L. Brown, ATC

260 N. Stephora Ave.
Covina, Ca, 91724

CMS-1429-P-1951

Submitter : Lindsay Arnold **Date & Time:** 09/18/2004 06:09:15

Organization : Whitworth College Athletic Training

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Therapy -- Incident To

CMS-1429-P-1951-Attach-1.doc

Attachment #1951

Lindsay Arnold
Whitworth College
300 W. Hawthorne Rd.
Spokane, WA 99251

September 13, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Dear Sir/Madam:

I am writing in response to the proposal that has been made to authorize physical therapists with the sole responsibility of providing physical medicine services to Medicare patients. The implementation of this proposal would prevent other qualified health care professionals, such as certified athletic trainers, from providing health care. It is not in the public's best interest to allow this proposal to become mandated.

By eliminating all other forms of competent health professionals from offering their services, the quality of care being offered will only be reduced. It is not in the best interest of the patients for this decision to be made. It is proven that a certified or licensed athletic trainer must possess a sufficient amount of knowledge and has been tested on their skills and training. Saying that a certified athletic trainer is not as competent as a physical therapist and will fail to offer the same amount of care is a false statement. It is essential that the public have a broad range of knowledge and different methods of thinking in order to receive care on a broad level. Not all patients are the same, so why should the professionals who treat them all be the same? Each person has a different need to be met. Our country is already experiencing a shortage of health care professionals who hold high enough credentials to treat Medicare patients. Why should we limit this number even more? That is not in the best interest of the people of this country. Limiting the number of health care providers limits the amount of people that can receive care each day.

Please allow certified athletic trainers to continue to do their job. Please allow the people of this country to continue to benefit from their training and education. The American public will only hurt if this proposal is passed.

Sincerely,

Lindsay Arnold

Submitter : Mrs. Kelly **Date & Time:** 09/18/2004 06:09:51

Organization : Mrs. Kelly

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

REGARDING: 'Therapy-Incident To'

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Subject: Medicare Program Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2005

I am a Physical Therapist currently working as the coordinator of rehab services. I have been a therapist for over 9 years in various clinical settings including Outpatient, SNF, Inpatient Acute Care, Acute Rehab, Home Health, and Schools. I have been a member of my professional organization, the APTA, since 1994.

I would like to comment on the August 5 proposed rule on Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005. I want you to know that I support CMS's proposal in the rule to establish proper standards for personnel providing physical therapy services in physician offices.

KEY POINTS:

Physical therapists working in physician offices SHOULD be graduates of accredited professional physical therapist programs.

Ensuring that all providers of physical therapy services are LICENSED PT's or PTA's would maximize patient safety and prevent patients from being misled. In many states, it would empower patients with the ability to verify the licensure status of their provider through online look-up systems.

Physical therapists and physical therapist assistants under the supervision of physical therapists are the only practitioners who have the education and training to furnish physical therapy services. Unqualified personnel should NOT be providing physical therapy services. Obtaining state licensure is a requirement in all 50 states; therefore physical therapists are fully accountable for their professional actions.

As of January 2002, the minimum educational requirement to become a physical therapist is a post-baccalaureate degree from an accredited education program. All programs offer at least a master's degree, and the majority will offer the doctor of physical therapy (DPT) degree by 2005.

The curriculums of PT and PTA programs include education of both normal and abnormal function of ALL AGES (newborn through geriatric). This differs significantly from programs such as Athletic Training, Kinesiology, and Exercise Physiology.
Physical therapists receive extensive training in anatomy and physiology, have a broad understanding of the body and its functions, and have completed comprehensive patient care experience in a variety of treatment settings. This background and training enables physical therapists to obtain positive outcomes for individuals with disabilities, illnesses, and injuries.

My grandmother was afraid to go to physical therapy because her friend (an elderly woman with osteoporosis) suffered compression fractures after going to what she called 'therapy' at the doctor's office. The treatment she actually received was NOT provided by a licensed PT or PTA, but by

an unlicensed person with limited training. These scenarios are all too common and are unfair to patients. We need to stop the deceptive practice of allowing physicians to bill for Physical Therapy services through the use of UNLICENSED and INADEQUATELY TRAINED personnel.

Thank you for your support of the Physical Therapy profession! We love what we do and believe we are an essential component to maximizing the health, well being and functional mobility of our patients.

Sincerely,

Mrs. Kelly

Issues 20-29

THERAPY - INCIDENT TO

REGARDING: Therapy-Incident To

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Subject: Medicare Program Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2005

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I would like to comment on the August 5 proposed rule on Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005. I want you to know that I support the CMS proposal to establish proper standards for personnel providing physical therapy services in physician offices.

KEY POINTS:

Physical therapists working in physician offices SHOULD be graduates of accredited professional physical therapist programs.

Ensuring that all providers of physical therapy services are LICENSED PT's or PTA's would maximize patient safety and prevent patients from being misled. In many states, it would empower patients with the ability to verify the licensure status of their provider through online look-up systems.

Physical therapists and physical therapist assistants under the supervision of physical therapists are the only practitioners who have the education and training to furnish physical therapy services. Unqualified personnel should NOT be providing physical therapy services. Obtaining state licensure is a requirement in all 50 states; therefore physical therapists are fully accountable for their professional actions.

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This differs significantly from programs such as Athletic Training, Kinesiology, and Exercise Physiology.
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My grandmother was afraid to go to physical therapy because her friend (an elderly woman with osteoporosis) suffered compression fractures after going to what she called 'therapy' at the doctor's office. The treatment she actually received was NOT provided by a licensed PT or PTA, but by an unlicensed person with limited training. These scenarios are all too common and are unfair to patients. We need to stop the deceptive practice of allowing physicians to bill for Physical Therapy services through the use of UNLICENSED and INADEQUATELY TRAINED personnel.

Thank you for your support of the Physical Therapy profession! We love what we do and believe we are an essential component to maximizing the health, well being and functional mobility of our patients.

Sincerely,

Mrs. Kelly

CMS-1429-P-1953

Submitter : Miss. Rachel Geoghegan **Date & Time:** 09/18/2004 06:09:51

Organization : National Athletic Trainers' Association

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

Please consider the following:

Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor?s or master?s degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70)percent of all athletic trainers have a master?s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT). I am currently a student in the midst of this eductaionly process, and in many of my classes, I sit next to students who will eventually be physical therapists. Even after I am certified, I will be required to maintain that certification according to set guidelines.

?Incident to? has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered.
The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY ?incident to? service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that
physicians continue to make decisions in the best interests of the patients.

Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes
to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers accompanied the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

CMS-1429-P-1954

Submitter : Mrs. Diana Irwin **Date & Time:** 09/18/2004 06:09:05

Organization : A Private Affair Diana's Speciality Shop

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

My store supplies mastectomy products. The ladies I supply to will require prosthestics and mastectomy bras for the rest of their lives. It does not make sense to continually put them through the inconvenience of making an appointment for the sole purpose of receiving a new prescription. Many of these ladies depend on others for their transportation. They have been through so much already, why add to the problem. I am certain that the doctors could better spend their time seeing patients in need of their services. This just compounds the problem patients have when trying to acquire an appointment when they need to see their doctor sooner.

CMS-1429-P-1955

Submitter : Mrs. Heather Fincham **Date & Time:** 09/18/2004 08:09:23

Organization : National Athletic Trainers Association-Member

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sir/Madam:
I am writing to express my concern over the proposal that would limit providers of 'incident to' services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these services. In turn, it would reduce the quality of health care for our Medicare patients and increase the costs associated with this service and place an undue burden on the health care system.During the decision-making process, please consider: 'Incident to' has been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers). There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. In many cases, the change to 'incident to' services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. It is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment. Patients who would now be referred outside of the physician's office would incur delays of access. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare. Curtailing to whom the physician can delegate 'incident to' procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians will take away from the physician's ability to provide the best possible patient care. To allow only Physical therapists and PT assistants, Occupational therapists and OT assistants, and speech and language pathologists to provide 'incident to' services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide 'incident to' care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services. CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services. CMS does not have the statutory authority to restrict who can and cannot provide services 'incident to' a physician office visit. Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists. Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified. These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept. It is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Submitter : Teresa Zepka **Date & Time:** 09/18/2004 08:09:52

Organization : Millersville University

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 18, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
PO Box 8012
Baltimore, MD 21244-8012

Re: Therapy-Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident-to? services in physician offices and clinics. Consumers deserve a choice to whom is providing their health care. Physicians should be determining which health care provider is better suited to provide rehabilitation for their patients.

Each of these equally qualified medical professionals deserves ?equal footing? in terms of reimbursement for the rehabilitation codes. In today?s world of rehab, consumers are exposed to and cared for by certified athletic trainers in physicians offices, rehabilitation companies, and industrial settings. If adopted, this would eliminate the ability of qualified health care professionals to provide these important ?incident-to? services.

Why now, is this proposal questioning the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service? Physicians continue to make decisions in the best interests of the patients. It is IMPERATIVE that Medicare and private payers continue to support physicians in these endeavors and not impose any limitations or restrictions as to who the physician can utilize to provide ANY ?incident-to? service.

CMS is surely receiving comments from Physical Therapists and Physical Therapist Assistants regarding this proposal. The APTA strongly opposes the use of ?UNQUALIFIED PERSONNAL? to provide services described and billed as physical therapy services. These individuals will speak of the ?negative impact? that will be created by allowing unqualified individuals to provide services that are billed as physical therapy services in physician?s offices. I could not agree more! Unqualified individuals should not be providing any medical service.

What those individuals will not tell CMS is this:

? All certified or licensed athletic trainers MUST have a bachelor?s or master?s degree from an accredited college or university.
? Core coursework for an ATC includes:
Human physiology and anatomy
Kinesiology/biomechanics
Nutrition
Acute care of injury and illness
Exercise physiology
Stats and research design
? 70% of all ATCs have a master?s degree or higher.
? The services and education of ATCs are comparable to other health care professionals including PTs, OTs, RNs, speech therapists, and many other mid-level health care practitioners.
? A Physical Therapy Assistant has 2-4 years less educational experience compared to an ATC, yet a PTA has a legislative right to be reimbursed for services. Why is this so?

Allowing only PT,OT, speech therapist to provide ?incident-to? outpatient therapy services would improperly provide these groups EXCLUSIVE rights to Medicare reimbursement and DENY the consumer access to quality health care professionals affecting the quality of health care being provided and possibly the costs.

In proposing this change, CMS offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care deterrent.
Respectfully,

Teresa Zepka, MS ATC PES
Assistant Athletic Trainer
Millersville University
Millersville, PA 17551

Submitter : Mr. Bryan McCloskey **Date & Time:** 09/18/2004 09:09:37

Organization : National Athletic Trainer's Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

CMS-1429-P-1957-Attach-1.doc

Attachment #1957

Bryan McCloskey, ATC
211 W. Pennsylvania Ave. #2
Downingtown, PA 19335

September 18, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Bryan McCloskey, ATC
211 W. Pennsylvania Ave. #2
Downingtown, PA 19335

CMS-1429-P-1958

Submitter : Lawrence Boyer **Date & Time:** 09/18/2004 10:09:23

Organization : Lawrence Boyer

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

I would like to inform you of my support for CMS requiring that items billed to medicare as physical therapy services be performed by a physical therapist or physical therapist assistant who meets the requirements set forth in CMS-1429-P. Our current knowledge of the human body and medical science in generl precludes any one discipline from knowing all there is to know. Thus, the approach to treating patients in today's environment is, and should be, interdisciplinary. Anyone who provides physical therapy services should be trained as a physical therapist as they are the ones with the knowledge of anatomy, physiology and kinesiology to deal with rehabilitation in the most professional and effective way. Just as an orthopedic surgeon is best qualified to deal with issues relating to the skeletal system, physical therapists are best qualified to deal with rehabilitaion issues. CMS should be committed to paying for the highest quality health care as this will generate the best outcomes and the lowest cost in the long run. Allowing unqualified individuals to perform and be reimbursed for services covered by CMS will only increase costs by decreasing the quality of care.

Sincerely,
Lawrence Boyer

CMS-1429-P-1959

Submitter : Mrs. Kathy Floyd **Date & Time:** 09/18/2004 10:09:10

Organization : Beautiful Creations, Inc.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

For the last 18 years, I have owned and operated a DME boutique that caters to ladies who have had mastectomies. The idea of requiring women who have had a mastectomy to obtain a prescription each time they need any mastectomy products would really create a hardship on many ladies. First, the situation is permanant and nothing is going to "grow back". Second, many physicians won't write prescriptions unless the person makes an appointment, often months in advance and then requires payment for an office visit. Third, many ladies need a new breast form in a hurry. Breast forms are not industructible and can develop problems quickly at times. I know one woman who didn't go to her granddaughters wedding because she didn't have a breast form that wasn't oozing all over the place. And finally, many of our medicare ladies go to warmer climates in the winter, so half of the time, they aren't even in the state. Can the script come from someone out of state? Or does it have to come from her regular doctor? If it does, will he require seeing her first before writing a prescription? It sounds far fetched, but I know several doctors who won't do much of anything for a patient he hasn't seen within a year or so. And when I recieve the script, do I have to send it to you as well? Do I accumulate a pile of them for each lady? Does the same hold true for mastectomy bras? What if she needs a bra and not a breast form? Does she still need a prescription?

There are even more questions, but I think the point is made. I keep all of my ladies original prescriptions on file. They have told me repeatedly how nice it is to be able to just come in and get things when they need them for their special needs and not have to worry about it. They appreciate feeling like an "ordinary customer" rather than someone with some deformity that requires doctors visits to remind them all the time. The idea is to get these women on with their lives. I just don't see how having to have a prescription for something that is clearly not going to change without a major surgery should require such a committment on these ladies part. One of the most common things I hear from women who are on Medicare, especially those who have just gone on it and left their private insurers is, "Wow! I don't believe it! Medicare really seems to understand that I NEED these things. Thank God, cause I'm really too tired to fight for them anymore." Please continue to understand.
Kathy Floyd, Beautiful Creations, 819 W. Second, Bloomington, In 47403

Submitter : Justin Gatewood **Date & Time:** 09/18/2004 11:09:39

Organization : Justin Gatewood

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 15, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

As a future Certified Athletic Trainer (ATC) and possible future patient, I feel compelled to write this letter in opposition of proposal CMS-1429-P. This proposal limits patient access to qualified health care providers of ?incident to? services, such as ATCs and others, in physician offices and clinics; thereby, reducing the quality of health care for physically active patients. Furthermore, limiting access to qualified health care providers cause health care delivery delays, which increases health care costs and tax an already heavily burdened health care system.

Athletic trainers are health care professionals recognized by the American Medical Association. They specialize in the prevention, assessment, treatment and rehabilitation of injuries to athletes and others engaged in physical activity. Athletic trainers are multi-skilled health care professionals who make significant contributions to health care. ALL certified or licensed athletic trainers must have a bachelor?s or master?s degree from an accredited college or university. A great majority (70%) of practitioners hold advanced degrees comparable to other health care professionals, including physical therapists, registered nurses, and speech therapists.

Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America. Dozens of athletic trainers served with the U.S. Olympic Team in Greece to provide health care services to our top athletes. For CMS to even suggest that athletic trainers are unqualified is outrageous and unjustified. Independent research demonstrates the quality of services provided by athletic trainers is equal to physical therapists.

?Incident to? has, since 1965, been utilized by physicians to allow others, with physician supervision, to provide services as an adjunct to the physician?s services. A physician has the right to delegate patient care to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and qualified. There have never been restrictions in terms of who can provide ANY ?incident to? service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the physician?s professional judgment to determine provider qualifications of a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

If this proposal would pass, it would threaten the employment of many athletic trainers who are employed as physician extenders in clinics and physician offices. Therefore this proposal threatens my future employment in those settings and the value of my degree in Athletic Training. With this type of limitation artificially placed on the provision of ?incident to? services by qualified (through accredited academic programs in athletic training, a national board examination, and state practice acts) health care providers the CMS will only add to the skyrocketing health care costs, put qualified people out of work, and reduce the overall quality of health care in the United States.

In summary, CMS offers no evidence of a problem and the CMS-1429-P proposal must be rejected. This appears as an effort to appease a single professional group who seeks to establish themselves as the sole provider of therapy services. The proposed changes are unjustified, not necessary and will diminish health care in the US.

CMS-1429-P-1961

Submitter : Miss. Kate Violette **Date & Time:** 09/19/2004 12:09:46

Organization : Northeastern University

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a student at Northeastern University who is currently in contention for a Doctorate of Physical Therapy (DPT) in 2006. At Northeastern, students complete cooperative education, or "co-op." One of the many benefits of the co-op experience is that students learn about their future careers, including the legislation surrounding them. This is especially true in the healthcare field. Personally, I have completed 18 months of co-op, and by the time I graduate, I will have had over two years of clinical experience. I have learned that there are many things that students, as the future of PT, have to fight for in terms of our place in the health care field.

There are fine lines between many of the related health care professions, and the lines are becoming more faded all the time. I will be in PT school for 6 years and 4 months. All of this time is spent learning everything that a PT needs to know when venturing out into the clinic after graduation. It enrages myself and my peers when someone compares us to Massage Therapists, Chiropractors, or even Personal Trainers. We train longer, learn more details, and prepare more completely for a career in the medical field than many of these professions. PT's deserve more credit than they receive, but we do not complain because the typical PT enters the field not for recognition, but for the feeling that we helped someone increase their quality of life. As a student, I am supporting this "incident to" because I feel like it is protecting the future of my profession.

Physicians are well trained, but they do not and cannot go into the detail of the anatomy of the human body in exactly the way that PT's do. That is why licensed PT's should be required when needed for referral from a physician. It is not about making changes, or taking business from doctors, it is about the preservation of a profession. Therefore, I am in strong support of CMS's proposed requirement that PT's working in physician's offices be licensed and graduates of accredited professional PT programs. Unqualified personnel who are not licensed should not be providing PT services. Licensure is a standard which would be appropriate to gauge if someone is knowledgeable in the field of PT. Licenses are awarded by each state where a PT wants to practice, and we are taught that this license is a privilege, not a right, and PT's can and will be held accountable for their professional actions.

As I have stated, PT's are educated thoroughly in the anatomy and physiology of the human body, and complete intensive training both in the classroom and in the patient care setting. All of this training enables PT's to create a personal and comprehensive treatment program for each individual patient. If this does not occur, it can be harmful to the patient, and potentially to the doctor. This unlicensed employee does not have the knowledge to put together a correct prescription for a patient. PT's are trained to look at the whole individual, whereas someone who has not received this training is not.

Finally, this proposal is important when considering the treatment of Medicare beneficiaries. A licensed PT knows what a patient actually needs, and therefore will reduce the costs of unnecessary tests and equipment. Also, a therapy cap is scheduled to become effective 1/1/2006. Therefore, under the current Medicare policy, a patient could exceed the cap without ever receiving services from a PT. This is detrimental to many patients who can benefit from PT. Most will end up returning to the physician time and time again, costing the government more money, when several visits to the PT could have prevented the problem from recurring. Patient education is one part of PT that is the most important.

Thank you for allowing my colleagues and I to voice our opinions, and for giving them consideration. As a student APTA member, I appreciate that my opinion matters and that I can possibly make a difference.

Sincerely,

Kate L. Violette, SPT

CMS-1429-P-1962

Submitter : **Date & Time:** 09/19/2004 01:09:56

Organization :

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Physical Therapy should only be provided directly by those trained in physical medicine / rehabilitation / therapy. I am aware of a number of physicans that hire medical assistants that have less than 120 hours of training and earn approximately $7 per hour and who have the medical assistants provide so called physical therapy to their patients while billing medical for the skilled services of a individual trained and licenced to perform physical therapy.

THERAPY STANDARDS AND REQUIREMENTS

As a physical therapist with a master's degree, I recognize the need for advanced training and am currently furthering my education through the pursuit of a doctorate degree in physical therapy. Based on my experiences in a variety of settings, I realize that many patients appear reasonably healthy yet have multiple co-morbidities which require the expertise of a licensed physical therapist or the direct care of a physician trained in physical medicine / rehabiitation. I do not believe that the best needs of the patient are met by untrained personnel providing "care" within the general supervison of a physician who may or may not be trained in physical rehabilative medicine. I feel that the needs of the patient, and the best method to prevent abuse of billing medicare for physical therapy services by unlicensed & inadequately trained personnel, would be met by requiring that all physical therapy provided in physican's offices (or otherwise) be reimbursed by Medicare ONLY IF PROVIDED BY A LICENSED PHYSICAL THERAPIST OR A PHYSICIAN TRAINED IN PHYSICAL MEDICINE / REHABILITATION. I also feel that many PHYSICAL THERAPY ASSISTANTS do not have the education, background or training to safely work with patients with multiple comorbidities and SHOULD BE REQUIRED TO PRACTICE ONLY UNDER THE DIRECT SUPERVISION OF LICENSED PHYSICAL THERAPISTS.

CMS-1429-P-1963

Submitter : **Date & Time:** 09/19/2004 01:09:02

Organization :

Category : Physician

Issue Areas/Comments

Issues 20-29

ASSIGNMENT

I am a practicing emergency physician in Ohio, having moved here from Florida last year. While in Florida I worked for InPhyNet, a Team Health affiliate. This organization is a large contract management group (CMG). I now work for a regional (CMG) with at least some partnership rights. Both companies made me sign contracts assigning payment of services to the companies. Almost all EM contract providers have contractual clauses stipulating the right of the employer to terminate the provider without cause. These CMGs perform all billing functions in the providers names. I have no way of knowing for certain if their billing departments are coding accurately. I fear that if I ask for access to the billing records, I would be immediately terminated without cause. It is imperative that these contract management companies who hire physicians that provide services at contracting hospitals be REQUIRED to notify their contracted physicians about all moneys received for billings done in a providers name. Merely requiring these CMGs to provide us "ACCESS" is potentially inviting fraud and abuse. Very few of my friends and colleagues would be willing to ask for access to our billing records for fear of being immediately terminated. Given that the providers are to be held liable for any overcharges by our CMGs to CMS, these CMGs should be required to provide us periodic billing statements, preferably monthly on what was coded, billed and collected in our name. Thank you for your attention to this problem. Please note that I have purposely left my name off the response page.

CMS-1429-P-1964

Submitter : Dr. Kim Albridge **Date & Time:** 09/19/2004 01:09:53

Organization : Dr. Kim Albridge

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

September 18 2004

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS Code 1429-P

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

I object to the Proposed Geographic Practice Cost Indices for 2005 because they fail to correct proven inadequacies in reimbursements to localities currently categorized as 'Locality 99' that exceed the 5 percent threshold (the '105% rule') over the national 1.000 average. Specifically, the new GPCIs exacerbate reimbursement deficiencies for the California counties of Santa Cruz, Sonoma, Monterey, San Diego, Sacramento, Santa Barbara and El Dorado.

In particular, the county of Santa Cruz, when broken out from Locality 99, would otherwise reflect a 1.125 percent GAF - higher than the California Localities 17 (Ventura), 18 (Los Angeles) and 26 (Orange). The boundary payment difference between Santa Cruz County and its neighboring county of Santa Clara (Locality 9) is a whopping 25.1 percent. Such statistics demonstrate the fallacy of the GPCI formula and demand CMS develop either exceptions to the current rules that would correct for the Santa Cruz situation or refine the formula to more accurately reflect the true cost of medical practitioners. Not to do so perpetuates an inherently unfair and discriminatory formula.

In its August 5 notice, CMS states that on the issue of payment localities '[a]ny policy that we would propose would have to apply to all States and payment localities.' Such an effort is commendable and bespeaks a desire to be fair to all physicians across the nation. However, the reality is that the governing statute does not prohibit individual State fixes or individual county or locality fixes. The CMS is not constrained by law from developing a strategy - with or without the concurrence of the state medical association - to correct the discrepancies in the reimbursement levels to California counties and I request that it do so as part of this rulemaking process.

CMS cannot postpone a solution this year as it did last year. Failure to address the GPCI/locality issue in California only grows the problems and will make fixing it all the more difficult in the future. Further, it threatens to undermine medical care to Medicare beneficiaries. Evidence from the local medical society shows an increasing trend toward doctors refusing to accept new Medicare patients. Many doctors are simply leaving the county to practice elsewhere, depleting the county of its medical resources. To implement the August 5 proposed rules would be counterproductive to CMS' mission to make Medicare benefits affordable and accessible to America's seniors.

I object to the Proposed Geographic Practice Cost Indices for 2005 as printed in the Federal Register of August 5, 2004. I request that CMS define

a method in which it can revise the GPCIs for those California counties - especially Santa Cruz - that exceed 5 percent of the national average and begin reimbursing doctors in those counties more appropriate to their true costs.

Sincerely,

Kim M. Albridge, M.D.

Submitter : Mrs. Rebecca Davidson **Date & Time:** 09/19/2004 02:09:16

Organization : Mrs. Rebecca Davidson

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I strongly support requiring that physical therapy services provided in a physician's office incident to a physician's professional services must be furnished by personnel who meet certain standards--namely that the PT provider be a licensed physical therapist. There is a world of difference in quality of care between an office aide trained by another aide, and a PT who has spent years working towards a degree in physical therapy, then passed state licensure requirements. Imagine being treated for leg pain for weeks without relief, when the source of the problem was actually at the spinal level. Licensed therapists are extensively trained in anatomy, biomechanics, and physiology and skillfully differentiate various sources of pain and disability. Physical therapy is not "physical therapy" unless provided by physical therapists and their assistants. The best tools in physical therapy are our educated minds and hands; to provide the trusting patient with anything less is a public disservice.

CMS-1429-P-1966

Submitter : **Debora Klinger** **Date & Time:** **09/19/2004 02:09:39**

Organization : **Trover Foundation Sports Medicine**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I wish to express my concern over the recent proposal that would limit providers of 'incident to' services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system. During the decision-making process, please consider the following:

** Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

** There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

** This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working 'incident to' the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

** Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

** CMS, in proposing this change, offers *no* evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

** CMS does not have the statutory authority to restrict who can and cannot provide services 'incident to' a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

** Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

** These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Debora S. Klinger, MS, ATC
Certified Athletic Trainer
36 Waddill Ave.
Madisonville, KY 42431

CMS-1429-P-1967

Submitter : **Date & Time:** 09/19/2004 02:09:45

Organization :

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please consider the attached comments when making your decision.

CMS-1429-P-1967-Attach-1.doc

Attachment #1967

Via Electronic Mail -- http://www.cms.hhs.gov/regulations/ecomments

Misty Miller, MS, ATC
UPMC Sports Medicine
172 Oakland Avenue
Uniontown, PA 15401

September 18, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- "Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.

- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor's or master's degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide "incident to" outpatient therapy in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions

deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.***

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Misty Miller, MS, ATC

CMS-1429-P-1968

Submitter : Mrs. Tracy Brown **Date & Time:** 09/19/2004 03:09:15

Organization : Mrs. Tracy Brown

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Physical therapy services provided in a physician's office incident to a physician's professional services must be provided by personnel who are licensed graduates of an accredited professional physical therapy education program since that is who is qualified to provide such treatment. To continue to allow Non- qualified personnel to provide 'physical therapy' services places the public at safety risk and misrepresents the profession of 'physical therapy'.

CMS-1429-P-1969

Submitter : **Date & Time:** 09/19/2004 03:09:35

Organization :

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

To Whom It May Concern:
This letter is written in regards to the Centers for Medicare and Medicaid Services proposal involving athletic trainers. The changes your organization is proposing would prevent reimbursement by Medicare or Medicaid for rehabilitative services provided by a certified athletic trainer working under the supervision of a physician, in a clinical setting. If this proposal is passed it will not only limit a physician?s ability to choose an appropriate healthcare provider for their patients, it will also inhibit the patient?s ability to receive competent, quality professional health care from individuals trained and specialized in this area.
A Certified Athletic Trainer?s scope of practice includes a variety of rehabilitative services in a number of settings, both clinical and non-clinical. They have extensive training in numerous evaluative techniques both on and off the field providing them with a strong knowledge base for providing excellent rehabilitative and therapeutic services.
The education criteria and clinical education experiences of an athletic trainer are extensive and in many instances more involved than those of Physical Therapy Assistants or Occupational Therapy Assistants, yet under your proposed changes they would still be covered by Medicare and Medicaid to continue working under a physician. Athletic trainers work in fields including professional sports, secondary schools, universities, health clubs, sports medicine clinics, corporate health programs and physicians? offices. Athletic trainers have an educational preparation in a variety of areas including pathology of illnesses and injuries, emergency care, therapeutic modalities, kinesiology, rehabilitation, reconditioning, treatment and therapeutic exercise. Athletic trainers who pass a certification exam outlined by the National Athletic Trainers Association (NATA) are highly qualified paramedical professionals, with an extensive background in education and practical, clinical experience in dealing with injuries. Many states require that athletic trainers continue their education by way of renewing their CPR certification and completing a certain number of continuing education credits. This allows athletic trainers to master new athletic training related skills and explore new knowledge related to athletic training. Physical therapists, however, are not required to continue their education. Also, according to the U.S. Department of Labor, athletic training is a higher rated job then physical therapy, physical therapy assistants, occupational therapy, and occupational therapy assistants. In short, athletic trainers are just as valuable to the medical field, if not more so, than PTs, PTAs, OTs, and OTAs. Athletic trainers are often the first ones to treat the athletes since they (the athletic trainers) are present at all sporting events and practices. When it comes to college athletes, therapy from the university?s certified athletic trainer may be the only therapy they are able to afford.
In looking back over the above mentioned reasons I am asking you to reconsider your proposal to prohibit reimbursement by Medicare and Medicaid for services provided by a certified athletic trainer. In looking out for the patients across the United States, it is in their best interest that you reconsider. We as healthcare professionals seek cooperation for the health and welfare and to achieve our goals of helping people who come to us for aid.

Sincerely,
Nicole M. Kramer

CMS-1429-P-1970

Submitter : Ms. Melissa Briscoe **Date & Time:** 09/19/2004 04:09:12

Organization : National Athletic Trainers Association

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am writting in concern to the proposed policy change which would limit physician "incident to" services to a very narrow population of health care practitioners. Currently, many people holding various degrees of knowledge concerning the human body, work in the health care field. It is through these people that the practice of medical art occurs. Liminting the practice span of an art so vast to a population of so few would be detrimental to the art itself. A painting is not made merely of primary colors, it is made through a combination of those colors, and through the artists hand we see clarity of his vision. The art of medecine has many hands.

Please continue to allow persons whom a physician deems qualified, to provide "incident to" services to your clients. By doing so you will be at least one of the hands helping create the art of medecine.

Submitter : Mr. Larry Korelc **Date & Time:** 09/19/2004 04:09:05

Organization : Minooka Pharmacy

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Mastectomy products shuld be excluded from the face-to-face prescription requirements. The effects of a mastectomy are permanent. Based on that fact, mastectomy products are necesary throughout the life of the recipient. Medicare already has parameters in place for the dispensation of these items. The parameters should be sufficient. The face-to-face prescription requirement would place an undue burden on all affected Medicare beneficiaries, physicians, suppliers and Medicare as well. The face-to-face prescription requirement will requie the recipient the inconvience of a visit to the physician, the physician's time for the visit, and Medicare's payment for the visit.

CMS-1429-P-1972

Submitter : Mr. Robert Baerman Jr, MS. ATC **Date & Time:** 09/19/2004 05:09:23

Organization : NATA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See attached document

CMS-1429-P-1972-Attach-2.txt

CMS-1429-P-1972-Attach-1.txt

Attachment #1972
Robert L. Baerman Jr. MS. ATC
Head Athletic Trainer
St. Joseph Regional High School
40 Chestnut Ridge Road
Montvale, NJ07645 9-19-04
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012
Re: Therapy – Incident To
Dear Sir/Madam:
I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.
During the decision-making process, please consider the following:
Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the

medical expenditures of Medicare.
Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists. Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.
I am also offended that while trying to send this comment, Athletic Trainers aren’t mentioned in your list of choices for Health Care Provider, which we most certainly are! Where is the justification that shows Certified Athletic Trainers don’t fall under the same terms of service that a physical therapist or occupational therapist are able to perform. Our profession obviously does not get the due respect from our peers, including parts of our government that seem bent on giving physical therapists any thing they so desire. It’s not fair
In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.
Sincerely,
Robert L. Baerman Jr. MS. ATC

Attachment #1972 (2 of 2)
http://www.cms.hhs.gov/regulations/ecomments

Robert L. Baerman Jr. MS. ATC
Head Athletic Trainer
St. Joseph Regional High School
40 Chestnut Ridge Road
Montvale, NJ07645

9-19-04

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system. During the decision-making process, please consider the following:

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I am also offended that while trying to send this comment, Athletic Trainers aren’t mentioned in your list of choices for Health Care Provider, which we most certainly are! Where is the justification that shows Certified Athletic Trainers don’t fall under the same terms of service that a physical therapist or occupational therapist are able to perform. Our profession obviously does not get the due respect from our peers, including parts of our government that seem bent on giving physical therapists any thing they so desire. It’s not fair

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.
Sincerely,
Robert L. Baerman Jr. MS

Submitter : Mrs. Vivian Mahoney **Date & Time:** 09/19/2004 05:09:19

Organization : Florida State Massage Therapy Association

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therpists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

CMS-1429-P-1974

Submitter : Ms. Kimberly Thoman **Date & Time:** 09/19/2004 07:09:48

Organization : Stony Brook University

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attached Letter Document...

Department of Health and Human Services
Centers for Medicare and Medicaid Services (CMS)
Offices of Strategic Operations and Regulatory Affairs

The attachment to this document is not provided because:

1. The document was improperly formatted.
2. The submitter intended to attach more than one document, but not all attachments were received.
3. The document received was a protected file and can not be released to the public.
4. The document is not available electronically at this time. If you like to view any of the documents that are not posted, please contact CMS at 1-800-743-3951 to schedule an appointment.

CMS-1429-P-1975

Submitter : Dr. STERLING LEWIS **Date & Time:** 09/19/2004 07:09:06

Organization : EMERGENCY MEDICAL GROUP

Category : Physician

Issue Areas/Comments

Issues 1-9

GPCI

September 2004

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS Code 1429-P

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

I object to the Proposed Geographic Practice Cost Indices for 2005 because they fail to correct proven inadequacies in reimbursements to localities currently categorized as "Locality 99" that exceed the 5 percent threshold (the "105% rule") over the national 1.000 average. Specifically, the new GPCIs exacerbate reimbursement deficiencies for the California counties of Santa Cruz, Sonoma, Monterey, San Diego, Sacramento, Santa Barbara and El Dorado.

In particular, the county of Santa Cruz, when broken out from Locality 99, would otherwise reflect a 1.125 percent GAF - higher than the California Localities 17 (Ventura), 18 (Los Angeles) and 26 (Orange). The boundary payment difference between Santa Cruz County and its neighboring county of Santa Clara (Locality 9) is a whopping 25.1 percent. Such statistics demonstrate the fallacy of the GPCI formula and demand CMS develop either exceptions to the current rules that would correct for the Santa Cruz situation or refine the formula to more accurately reflect the true cost of medical practitioners. Not to do so perpetuates an inherently unfair and discriminatory formula.

In its August 5 notice, CMS states that on the issue of payment localities "[a]ny policy that we would propose would have to apply to all States and payment localities." Such an effort is commendable and bespeaks a desire to be fair to all physicians across the nation. However, the reality is that the governing statute does not prohibit individual State fixes or individual county or locality fixes. The CMS is not constrained by law from developing a strategy - with or without the concurrence of the state medical association - to correct the discrepancies in the reimbursement levels to California counties and I request that it do so as part of this rulemaking process.

CMS cannot postpone a solution this year as it did last year. Failure to address the GPCI/locality issue in California only grows the problems and will make fixing it all the more difficult in the future. Further, it threatens to undermine medical care to Medicare beneficiaries. Evidence from the local medical society shows an increasing trend toward doctors refusing to accept new Medicare patients. Many doctors are simply leaving the county to practice elsewhere, depleting the county of its medical resources. To implement the August 5 proposed rules would be counterproductive to CMS' mission to make Medicare benefits affordable and accessible to America's seniors.

I object to the Proposed Geographic Practice Cost Indices for 2005 as printed in the Federal Register of August 5, 2004. I request that CMS define

a method in which it can revise the GPCIs for those California counties - especially Santa Cruz - that exceed 5 percent of the national average and begin reimbursing doctors in those counties more appropriate to their true costs.

Sincerely,

Sterling F. Lewis, D.O.
Emergency Physician
Watsonville Community Hospital
Watsonville, Ca., 95076

Submitter : Mrs. Maueeen Gilbert **Date & Time:** 09/19/2004 11:09:55

Organization : Florida State Massage Therapy Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I implore you NOT to pass this policy whereby a physician can only refer "incident to" services to physical therpists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Mr. Saverio Campano **Date & Time:** 09/19/2004 11:09:24

Organization : Florida State Massage Therapy Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We implore you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therpists. ALL qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Mr. Dennis Lencioni **Date & Time:** 09/19/2004 01:09:24

Organization : Gottlieb Memorial Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

Department of Health and Human Services
Centers for Medicare and Medicaid Services (CMS)
Offices of Strategic Operations and Regulatory Affairs

The attachment to this document is not provided because:

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2. The submitter intended to attach more than one document, but not all attachments were received.
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4. The document is not available electronically at this time. If you like to view any of the documents that are not posted, please contact CMS at 1-800-743-3951 to schedule an appointment.

Submitter : Miss. Erica Anderson **Date & Time:** 09/19/2004 01:09:11

Organization : Florida State Massage Therapy Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therpists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

CMS-1429-P-1980

Submitter : Dr. Kenneth Koenig **Date & Time:** 09/19/2004 02:09:22

Organization : private practice

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am a physician in private practice for 33 years. I am now close to retirement age. So your decisions will only affect me as a senior and private citizen. I would like to urge you to please reconsider the designation of Santa Cruz County in California as a "rural" county for medicare payment levels to physicians. I have lived here for over 20 years. This county has changed drastically during that time population wise and health care wise. We need good physicians. We are a rather isolated community as our closest larger town, San Jose, is not easily accessible except through a difficult drive often with much traffic. We must have access to good physicians and medical care. Continuing the current fiscal policy means driving otherwise excellent physicians out of business and the inability to attract new physicians in their place. Thanks for considering my request.

CMS-1429-P-1981

Submitter : Mr. Robert Poulin **Date & Time:** 09/19/2004 02:09:12

Organization : Florida State Massage Therapy Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do not pass any policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers, including Licensed Massage Therapists, should be allowed to provide services to patients with a physicians prescription or under their supervision.

CMS-1429-P-1982

Submitter : Mr. yosri gendi **Date & Time:** 09/19/2004 02:09:09

Organization : PS 396

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Please approve this policy for the good interests and safety of our medicare patients . physical therapists are the only qualified professionals to administer physical therapy services.

CMS-1429-P-1983

Submitter : Mrs. Judith Dardzinski **Date & Time:** 09/19/2004 02:09:23

Organization : Mrs. Judith Dardzinski

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Regarding "Therapy- Incident to"
I feel strongly that the care of the patient must be kept to the level of competency and quality that they expect when receiving Physical THerapy. Only a licensed physcial therapist or assistant with proof of graduation from an accredited school and carrying a current license of the state in which they practice should be allowed to provide and bill for physical therapy services. With limited financial resources and with the possibility of limited ourpatient physcial therapy vistis for the Medicare patient, I ask you to continue to enforce the requirement that " physical therapy" services by provided by only Physical therapist or PT assistant under proper supervision.
Thank you for your consideration in this matter.
Sincerely,
Judith Dardzinski

CMS-1429-P-1984

Submitter : Ms. Michele Mathiesen **Date & Time:** 09/19/2004 03:09:10

Organization : Florida State Massage Therapy Assoication

Category : Other Technician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do not send Medicare patients to Physical Therapists only. This would be a huge mistake on your part. PT while useful in it's own right is most effective when combined with a Neuromuscular Massage Therapy program. Most PT's have zero palpation skills and are solely concerned with the functionality of the patient so they push them beyond their capabilities to try to make their "success" rate look better by giving the patient new problems to take the place of their old ones. I have watched this time and time again. MOst PT's are unable to create a cohesive treatment plan and it is usually the NMT's (Neuromuscular Massage Therapists) that end up determining the plan of attack as they have spent the most time with the client and have palpation skills that are thousands of times better than any PT!

I have been working over a year on strictly Medicare Patients and the reason they get better is not PT - I will stake my reputation, career and livelihood on it. Massage is not some joke. A reputable therpaist can lower blood pressure, help the exchange of lymph fluid, release restriction in both the cranium and spinal cord, reduce pain in almost every circumstance, relieve and drastically reduce chronic pain symptoms, decrease inflammation responses, reduce stress levels resulting in better overall health and unlike PT's we actually spend time with these clients ensuring them proper treatment.

PT's typically have 4-5 patients an hour and work on all of them at the same time. NMT's only have 1 patient an hour (or half hour) and spend all of the time with the patient. We are not ocncerned ONLY about the functionality of the patient in regards to the ADL's. THis is ridiculous! It is like putting a cast on a broken arm and saying you've fixed it! You have not fixed it! You have barely done the most minimal of treatment and the person has healed themself. This person will need therpay to rebuild the muscle, stretch the tendons and ligmaents and release adhesions at the articulation in all of the soft tissue. You will not get this thru PT's as they can't feel any of the above. They will just look at the chart and worry about your range of motion and do nothing to try to increase it other than forcing the issue.

PT's version of therapy is too simplistic for an aging clientele. Every pain (according to PT) is a site of muscular weakness. So therefore strengthening the muscle is their primary goal thinking the flexibility will return with it. This is primitive at best. Until you can develop palpation skills you will never be able to find the real problem not just part of the symptoms. Treating the symptoms will relieve the problem in the short term but it will return, usually worsened, and then the client has lost motivation to get better as they have been down this route before. You must treat the entire problem, not just shoot it up with drugs and painkillers as is our Western medicine practice. Upon treating the entire problem you will cure the problem and all the symptoms. You must have skills beyond paperwork and a 4 year degree to do this. I too have 3 degrees plus 4 different certifications for a variety of healing procedures. This is more than any PT I have ever worked with!

You goal is to help Seniors. Western medicine just gives them more drugs and relies on a $10 an hour Pharmacy Tech to make sure they will not have drug interactions. This is a joke and far from civilized. Our country and our version of medince are still in it's infancy. Other types of medicine have been around for thousands of years. Your wanting to turn your back on alternative complementary therapies when they are increasingly becoming part of the mainstream modes of treatment suggest you do not want better care for Seniors.

Maybe you should go to PT and to an NMT and see for yourself which really works! I guarantee you that you will rethink your proposition and make NMT's Medicare providers!

Submitter : Ms. Jean Blum **Date & Time:** 09/19/2004 03:09:00

Organization : Florida State Massage Therapy Association

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. ALL qualificed health care providers should be allowewd to provide services to patients with a physicians prescription or under their supervision.

CMS-1429-P-1986

Submitter : Patricia Blanchette **Date & Time:** 09/19/2004 03:09:41

Organization : concerned retired woman

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Santa Cruz County in California is unique. We are very small but filled to the brim with people who love to live near the ocean and in the trees. Our county has changed dramatically in the past 20 years in numbers and in median price of homes and in median salaries. WE ARE NOT A RURAL AREA. YOU SHOULD NOT BE USING A "MAP" DRAWN ALMOST 40 YEARS AGO. TIMES CHANGE!!! PLEASE!!!!!

Submitter : Ms. Sandra Rice **Date & Time:** 09/19/2004 03:09:11

Organization : Ms. Sandra Rice

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do NOT pass this policy whereby a physician can only refer "incident to" services to physical therpists. All qualified health care providers should be allowed to provide services to patients with a physician's prescription or under their supervision.

CMS-1429-P-1988

Submitter : Dr. Norman Latov **Date & Time:** 09/19/2004 03:09:31

Organization : Dr. Norman Latov

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

This is regarding proposed reimbursement of office infusion of IVIg. Our office, and other offices that we know, will no longer be able to provide IVIg infusions, as the reimbursement formula would not cover their costs, if one takes into account the cost of nursing, facilities, storage, administration, billing, etc. Consequently, we, and others will be sending our patients to the hospital for the infusions instead, where the additional facility fees will probably double the current cost of the infusions to Medicare. This is a foolish and short sited policy change, which ignores the personal and financial benefits of having patients cared for in physicians' offices, rather than at institutions who's focus is the more costly inpatient care.

CMS-1429-P-1989

Submitter : dennis abma **Date & Time:** 09/19/2004 03:09:20

Organization : dennis abma

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Having lived in Santa Cruz County for sixty years, I believe that it was correctly classified as rural in the fifties, or even the sixties, but with median home prices among the highest in the country, its time to re-evaluate that classification.

Dennis Abma

Submitter : Mr. M C Markman **Date & Time:** 09/19/2004 03:09:48

Organization : Florida Massage Therapy Association

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

IMPACT

Massage among all the various modalities available has proven to have positive results on people with injuries, as well as the elderly who are seeking rehabilitation to refuse them access to these services because of finantial limitations would be a truly sad state of affairs. I beg you please do not allow this to happen.
Truly,

M C Markman

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therpists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Dr. Lawrence Birndorf **Date & Time:** 09/19/2004 04:09:05

Organization : Dr. Lawrence Birndorf

Category : Physician

Issue Areas/Comments

Issues 1-9

GPCI

See attached Letter

CMS-1429-P-1991-Attach-1.doc

Attachment #1991

September 2004

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS Code 1429-P

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

I object to the Proposed Geographic Practice Cost Indices for 2005 because they fail to correct proven inadequacies in reimbursements to localities currently categorized as "Locality 99" that exceed the 5 percent threshold (the "105% rule") over the national 1.000 average. Specifically, the new GPCIs exacerbate reimbursement deficiencies for the California counties of Santa Cruz, Sonoma, Monterey, San Diego, Sacramento, Santa Barbara and El Dorado.

In particular, the county of Santa Cruz, when broken out from Locality 99, would otherwise reflect a 1.125 percent GAF - higher than the California Localities 17 (Ventura), 18 (Los Angeles) and 26 (Orange). The boundary payment difference between Santa Cruz County and its neighboring county of Santa Clara (Locality 9) is a whopping 25.1 percent. Such statistics demonstrate the fallacy of the GPCI formula and demand CMS develop either exceptions to the current rules that would correct for the Santa Cruz situation or refine the formula to more accurately reflect the true cost of medical practitioners. Not to do so perpetuates an inherently unfair and discriminatory formula.

In its August 5 notice, CMS states that on the issue of payment localities "[a]ny policy that we would propose would have to apply to all States and payment localities." Such an effort is commendable and bespeaks a desire to be fair to all physicians across the nation. However, the reality is that the governing statute does not prohibit individual State fixes or individual county or locality fixes. The CMS is not constrained by law from developing a strategy - with or without the concurrence of the state medical association - to correct the discrepancies in the reimbursement levels to California counties and I request that it do so as part of this rulemaking process.

CMS cannot postpone a solution this year as it did last year. Failure to address the GPCI/locality issue in California only grows the problems and will make fixing it all the more difficult in the future. Further, it threatens to undermine medical care to Medicare beneficiaries. Evidence from the local medical society shows an increasing trend toward doctors refusing to accept new Medicare patients. Many doctors are simply leaving the county to practice elsewhere, depleting the county of its medical resources. To implement the August 5 proposed rules would be counterproductive to CMS' mission to make Medicare benefits affordable and accessible to America's seniors.

I object to the Proposed Geographic Practice Cost Indices for 2005 as printed in the Federal Register of August 5, 2004. I request that CMS define a method in which it can revise the GPCIs for those California counties - especially Santa Cruz - that exceed 5 percent of the national average and begin reimbursing doctors in those counties more appropriate to their true costs.

Sincerely,

Lawrence Birndorf, MD

Submitter : Ms. Barbara Brogan **Date & Time:** 09/19/2004 04:09:31

Organization : Ms. Barbara Brogan

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

The definition of counties as rural which forms the basis of physical payments is long outdated. I live in Santa Cruz California where the median price of a home is over $600,000. We are losing physicians to other areas where they receive higher payments from Medicare and might be able to afford a home (much less think about paying their debt incurred in getting their education). I have had 3 drs. in one year because they are forced to leave the area. This is crippling health care in our area. The designation of counties as rural or urban needs to be routinely reviewed. A lot has changed since 1967!!!

Submitter : Ms. Mary Alyce Keith **Date & Time:** 09/19/2004 05:09:50

Organization : individual person

Category : Occupational Therapist

Issue Areas/Comments

GENERAL

GENERAL

I agree with the proposed changes related to Occupational Therapy treatment by qualified persons under consistent descriptions of supervision as other Medicare areas of practice. Thank you for your thoughtful changes that reflect better quality of care and better clarification of service and payment.

CMS-1429-P-1994

Submitter : Mr. Dmitry Shestakovsky **Date & Time:** 09/19/2004 05:09:30

Organization : Omega Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

"Therapy-Incident"

I wish to comment on the August 5th proposed rule on " Revision Under the Physician Fee Schedule for Calendar Year 2005." In the proposed establishing requirements for individuals who furnish outpatient physical therapy services in physician offices. CMS proposed that qualifications of individuals providing "incident to" a physician should meet personal qualifications for physical therapists with the exception of licensure. This means that individuals providing physical therapy must be graduates of an accredited professional physical therapist program.

I personally strongly support for CMS's proposed requirement that physical therapists working in physician offices be graduates of accredited professional physical therapy programs with the value of licensure as a STANDARD. The reasoning behind this stems from the fact that physical therapists and physical therapy assistants are the only practioners that have extensive education in providing physcial therapy services. All physical therapy programs offer at least a master's degree, and most offer a doctorate degree in physical therapy. Physical therapists recieve significant training in anatomy, physiology, kinesiology, manual therapy as well going through many clinical rotations in top hospitals. This background and training enables physical therapists to effectively treat individuals with disability and other conditions needing education and training, particulary important when treating MEDICARE beneficiaries.

This so - called "physical therapy" provided by unqualified personal such as massage therapists, secretaries, exercise physilogists, athletic trainers, chiropractors can and will be harmfull. I have been practicing physcial therapy in brooklyn, new york for five years. In that time i have personally witnessed several physician owned offices employ non qualified personal to perform physical therapy. I have seen chiropractors ulrasound knees of 15 years old boys, with the epiphyseal plates still not closed. I have seen massage therapist provide dangerous and improper manipulations and mobilizations to patients. I have seen simple aides put electric stimulation on joint replacements exc...

The reason this happens in that physicians, who some are not trained in physical rehabiliation hire these individuals for the sole purpose of paying them less to perform physical therapy services than the would have to pay a licensed physical therapist. One can see that this is pure formula for failure not just for the profession of medicine and physical therapy but for our patients as well.

Sincerly,
Dmitry Shestakovsky, P.T.

CMS-1429-P-1995

Submitter : Itoro Victor **Date & Time:** 09/19/2004 05:09:31

Organization : Itoro Victor

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

To Whom It May Concern:

My name is Itoro Victor and I am a junior at Boston University. I am writing regarding the proposal to disallow physicians to be reimbursed for therapy services administered by a certified athletic trainer in a physician's office. As I am currently enrolled in a combined Athletic Training/Doctoral Physical Therapy program, I am able to experience both athletic training and physical therapy classes. I was originally only in the Doctoral Physical Therapy program, but transferred out as I saw that athletic training offered a great deal more opportunities for learning. I take many of the same classes as the physical therapy students and I find that they seem to have more trouble with the material. I would attribute that to the fact that in athletic training, we start off right away in a clinical experience so that by the time that we graduate we will feel very knowledgeable and comfortable in our work settings. The physical therapy students will eventually work in clinical settings, but as my fellow Athletic Training /Doctoral Physical Therapy classmates and I matriculate into the doctoral part of the Physical Therapy program, we will have had 3 years of experience over the other Physical Therapy juniors, yet we will all graduate at the same time. I am confident that the Physical Therapy doctoral program will force the Physical Therapy students to eventually 'catch-up' with us, but to even suggest that Physical Therapy students will graduate more qualified than us is absolutely absurd. One of the things that attracted me to the field of athletic training is that as an athletic trainer I will be there to see the injury happen, provide immediate care, and do the treatment and rehabilitation later. There is no other profession that demands such a vast amount of information to be retained and used at a moment's notice. Other health care providers either do the first response treatment or the rehabilitation part, but the fact that athletic trainers are willing to take on full responsibility should only be commended, not discouraged by people trying to limit our ability to practice. The patient's best interest will be compromised by limiting athletic trainers' ability to practice because it will add unnecessary delays in the process. Since athletic trainers are educated and trained in first response and rehabilitation, we are able to see that our patients succeed throughout the entire treatment process. Without athletic trainers, patient care will be delayed because after seeing a physician they may have to wait to get an appointment with a therapist, which in turn will hinder recovery time, thus add to medical care expenditures anyway. Therefore, it is disadvantageous for CMS to implement the changes proposed.

Sincerely,

Itoro Victor

Submitter : Mr. Alex Ivashenko **Date & Time:** 09/19/2004 05:09:12

Organization : Mr. Alex Ivashenko

Category : Physical Therapist

Issue Areas/Comments

Issues 10-19

DEFINING THERAPY SERVICES

Many physicians who have seen their income drop have added Physical Therapy services as another profit center for to maintain their lifestyle. It is hard to believe that physicians do not have access to high quality physical therapy in their communities. In fact, we should be extremely vigilant policing rehabilitation and medicine in general due to todays enviornment of Medicare abuse and fraud (studies show up to 10 percent of the Medicare budget goes to fraudulant services).

I hope that the government will see through the facade of physicians using unlisenced personnel to treat people with equipment that can hurt or permanently injure their patients.

Lastly, studies show that physicians who self refer typically charge more and treat patients longer than independent practices.

Thank you for your consideration in this matter.

Submitter : Dr. Sharon Stotsky **Date & Time:** 09/19/2004 06:09:52

Organization : Rheumatology and Internal Medicine Associates

Category : Physician

Issue Areas/Comments

Issues 1-9

SECTION 303

Comment on CMS regulation 1429P ? Section 303

I am a community based solo rheumatologist with 2 FTE mid-level providers servicing approximately 5000 patients. I am concerned that the proposed in-office infusion of Infliximab reimbursement rates will threaten the economic viability of this practice to continue to service Medicare patients. In that case, I will be forced to refer patients for that service to institutions where the costs to CMS will be substantially higher than those currently experienced for in-office delivery of this service. Patient satisfaction is also much higher when infused in physician offices rather than in hospitals.

You goal appears to be to provide physicians with a 6% margin on the medication to reflect the cost of acquiring the medication and administering an in-office program. The new ?G? codes are to be established to compensate us fairly relative to other specialties delivering similar services. Presumably the reimbursement provided by these codes will cover the cost of staff time, physician time, a proportion of fixed costs incurred by time period, and the direct and indirect variable costs associated with delivering these services. My calculation show that with our current direct costs of purchasing the medication from authorized distributors and your proposed reimbursement of 53.32 per unit we realize a gross margin closer to 3% rather than the 6% goal noted in your documents. This difference is probably due to the distributor being in the supply chain and earning a margin. Our volume of Infliximab is high relative to many other providers so we believe we are getting better pricing than other practices. This is not enough margin to do this in the office.

While we have not seen the proposed reimbursement rates for the new infusion ?G? codes, we would expect that these rates would offset the loss in compensation from lowered gross margin on the drug from the current 12% level. We need a revenue stream comparable to current levels to cover all costs and to enable us to realize a fair reimbursement comparable to physicians in other specialties delivering similar infusion services such as oncology.

Please set the rates of all codes and services associated with in-office infusion of Infliximab and other similar effective medication to remain economically viable to the small community based physician practice. This is where Medicare beneficiaries are most effectively serviced. The total amount paid for the work delivered needs to be appropriate and fair.

Submitter : Mr. Florim Bajraktari **Date & Time:** 09/19/2004 06:09:19

Organization : Northeastern University Student Athletic Trainers

Category : Health Care Provider/Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Florim Bajraktari
150 Huntington Ave apt # SA4
Boston MA, 02115

September 19, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

? There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY ?incident to? service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

? Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor?s or master?s degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master?s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

? CMS does not have the statutory authority to restrict who can and cannot provide services ?incident to? a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.

? Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who

becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Florim Bajraktari

CMS-1429-P-1999

Submitter : Ms. Florence Law **Date & Time:** 09/19/2004 06:09:12

Organization : FSMTA

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Please do NOT pass CMS 1429P